

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER West Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W Washington Ave South Bend, IN 46619	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident's responsible party was notified timely of new medication and the risks and benefits of the medication, prior to administration of the medication, for 1 of 3 residents reviewed for notification, (Resident B).</p> <p>Finding includes:</p> <p>On 6/18/25 at 9:43 A.M., a telephone interview with the Social Service Director (SSD) at a local dialysis center indicated Resident B received dialysis at the dialysis center on Mondays, Wednesdays and Fridays and had received dialysis for several months. The SSD indicated the facility had notified the dialysis center, on 3/14/25, that Resident B had been prescribed Ativan (a central nervous system depressants which slows down the nervous system and is used to treat anxiety) before his dialysis appointments. The dialysis SSD indicated Resident B had been coming to dialysis treatments, lethargic and out of it over the past few weeks and, on 5/28/25, she had notified the Director of Nursing and requested a discontinuation of the Ativan medication. The dialysis SSD indicated there was a note in the resident's communication book that indicated the resident had been figgity at an appointment, on 2/14/25, and there was no further documentation of negative behaviors during dialysis treatments.</p> <p>During an interview on 6/18/25 at 10:20 A.M., the facility Memory Care Director indicated, on 3/13/25, she was directed by the Director of Nursing to call the facility's Psychiatric Nurse Practitioner to request an order for medication to calm the resident while he received dialysis. The Memory Care Director indicated she had called and made the request to the Psychiatric Nurse Practitioner, who then prescribed Ativan 0.5 mg to be taken by mouth every Monday, Wednesday and Friday before leaving the facility for dialysis. The Memory Care Director indicated, on 3/13/25, during a telephone Care Plan meeting with the resident's responsible party, the resident's medications were reviewed but the addition of Ativan was not discussed. The Memory Care Director indicated she had not notified Resident B's responsible party that the resident was receiving Ativan at the time of the initial administration on 3/10/25.</p> <p>During an interview with the Assistant Director of Nursing, on 6/18/24 at 10:30 A.M., she indicated she had not notified Resident B's responsible party that Ativan had been prescribed for anxiety prior to dialysis treatments. The Assistant Director of Nursing indicated, on 3/13/25, during a telephone Care Plan meeting, she had listed the resident's medications, and that Ativan must have been mentioned, but it had not been discussed with the responsible party.</p> <p>,</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 6/18/25 at 11:00 A.M., with the Director of Nursing, she indicated the only documentation of notification to the resident's responsible party regarding the order to start Ativan was in the resident care plan note, on 3/13/25. The Director of Nursing indicated she had not notified Resident B's responsible party that Ativan had been prescribed.</p> <p>Resident B's clinical record was reviewed on 6/19/25 at 10:00 A.M. Diagnoses included but were not limited Alzheimer's disease, vascular dementia, chronic kidney disease, and adjustment disorder with anxiety.</p> <p>A physician's order dated from 3/11/25 to 5/28/25, indicated Ativan tablet 0.5 mg was to be administered by mouth once a day on Monday, Wednesday, and Friday before dialysis for the diagnosis of adjustment disorder with anxiety.</p> <p>Review of the Medication Administration Record (MAR), indicated Resident B had received Ativan 0.5 mg every Monday, Wednesday, and Friday from 3/10/25 to 5/28/25.</p> <p>Review of Resident B's Care Plan Summary, dated 3/13/25 at 1:19 P.M., indicated medications were reviewed with Resident B's responsible party and she was aware of the risks associated with the medications and had no concerns.</p> <p>On 6/18/25 at 10:01 A.M., the Administrator provided a policy titled, Resident Change of Condition, dated 11/2018, and indicated it was the current facility policy. The policy indicated, It is the policy of this facility that all changes in resident condition will be communicated to the .responsible party .The nurse in charge is responsible for notification of .responsible party prior to end of assigned shift when a significant change in the resident's condition is noted .Documentation will include time and [responsible party] response .</p> <p>This citation relates to Complaint IN00460484.</p> <p>3.1-5(a)(3)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was free from chemical restraint related to medication administered for the purpose of calming the resident prior to off-site dialysis treatments, for 1 of 3 residents reviewed for chemical restraints, (Resident B).</p> <p>Finding includes:</p> <p>During an observation, on 6/17/25 at 10:18 A.M., Resident B was in the common area of the Memory Care unit seated upright, alert and watching the activities of the other residents in the area. The resident was well-groomed and nicely dressed. The resident showed no signs of any negative behaviors.</p> <p>During an observation, on 6/18/27 at 9:48 A.M., Resident B was in the common area of the Memory Care unit, seated in a chair along with other residents in the area. Resident B was clean, well dressed, appeared alert and showed no signs of negative behaviors.</p> <p>During an interview, on 6/18/25 at 9:43 A.M., with the Social Service Director (SSD) from a local dialysis center, she indicated Resident B received dialysis at the dialysis center on Mondays, Wednesdays, and Fridays, and had been receiving dialysis treatments for several months. The SSD indicated the facility had notified the dialysis center, on 3/14/25, that Resident B had been prescribed Ativan (a central nervous system depressants, which slows down the nervous system and is used to treat anxiety), before his dialysis appointments. The dialysis SSD indicated Resident B had been coming to dialysis, lethargic and out of it over the past few weeks and, on 5/28/25, she had notified the Director of Nursing and requested a discontinuation of the Ativan. The dialysis SSD indicated there was only one note in the resident's communication book that indicated the resident had been figgity at an appointment, on 2/14/25, and there was no further documentation of negative behaviors during his dialysis treatments.</p> <p>During an interview, on 6/18/25 at 10:20 A.M., the Memory Care Director indicated, on 3/10/25, she was directed by the Director of Nursing to call the facility's Psychiatric Nurse Practitioner to request an order for medication to calm the resident while he received dialysis treatments. The Memory Care Director indicated she had called and made the request to the Psychiatric Nurse Practitioner, who then prescribed Ativan 0.5 mg to be taken by mouth every Monday, Wednesday, and Friday before leaving the facility for dialysis treatments. The Memory Care Director indicated Resident B was very pleasant and easily redirected, though he could get agitated if he was seated for long periods of time. She indicated the facility always sent a Certified Nursing Assistant (CNA) to sit with the resident during dialysis treatments. The Memory Care Director indicated it was reported to her, on 2/14/25, that Resident B had been figgity at his appointment and had pulled at his infusion port. The Director of Memory Care indicated there had been no other reports of figgiting or behaviors that she had been aware of for Resident B. The Director of Memory Care indicated no assessments had been completed by the facility or the Psychiatric Nurse Practitioner to determine the resident's medical need for the Ativan medication and there were no assessments completed following the administration of the medication. The Memory Care Director indicated she had observed no behaviors in the resident that would warrant the need for Ativan.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Assitant Director of Nursing, on 6/18/24 at 10:30 A.M., she indicated the facility did not start psychotropic medications, such as Ativan, unless they had documented, unwanted behaviors or anxieties demonstated by the resident for at least three days. Unwanted behaviors were then reported to the Psychiatric Nurse Practitioner who determined the necessary treatment. The Assistant Director of Nursing indicated there was no supportive documentation regarding Resident B, and the Psychiatric Nurse Practitioner had not assessed the resident before prescribing Ativan.</p> <p>During a telephone interview on 6/18/25 at 10:40 A.M. on the Assistant Director of Nursing's telephone, the Psychiatric Nurse Practitioner indicated on 3/10/25, she had initiated a new order for Ativan 0.5 mg to be administered to Resident B, before dialysis on every Monday, Wednesday, and Friday, due to a report from the Director of Nursing that the dialysis center had requested Resident B have something to address his restlessness and anxiety during dialysis. The Psychiatric Nurse Practitioner indicated the medication was discontinued, on 5/28/25, at the request of the dialysis center because the resident was lethargic.</p> <p>During an interview with the Director of Nursing, on 6/18/25 at 11:00 A.M., she indicated in March the dialysis center had reached out to her to report agitation in the resident, and felt he may have needed something to help him to relax. The Psychiatric Nurse Practitioner had ordered Ativan 0.5 mg to be administered by mouth before dialysis appointments. The Director of Nursing indicated no further concerns had been communicated to the facility, until 5/28/25, when the dialysis center indicated Resident B was too groggy to complete his treatments. She indicated the Ativan had been discontinued, at that time, at the request of the dialysis center. The Director of Nursing indicated there had been no behavioral assessments completed by the nursing staff or the Psychiatric Nurse Practitioner prior to the initiation of the medication and there were no follow-up assessments to address the resident's response to the Ativan or to monitor for any adverse side effects.</p> <p>Resident B's clinical record was reviewed on 6/19/25 at 10:00 A.M. Diagnoses included but were not limited Alzheimer's disease, vascular dementia, chronic kidney disease, and adjustment disorder with anxiety.</p> <p>Review of the resident's dialysis communication book from 2/1/25 to 6/16/25, indicated on 2/14/25 the resident was figgity and pulling at his dialysis port. No other entries concerning negative behaviors had been communicated.</p> <p>A note from the dialysis center, dated 5/29/25, was provided by the dialysis center on 6/18/25 at 10:07 A.M. The note indicated the dialysis center had notified Resident B's responsible party that the CNAs sitting with the resident to dialysis were frequently leaving him unattended and that the resident had arrived to dialysis lethargic due to Ativan. The note indicated the responsible party was not aware of the Ativan use and that he had been active and moving during her visits at the facility. She had reported she felt the Ativan was an appropriate substitution for a sitter.</p> <p>A physician's order dated from 3/11/25 to 5/28/25, indicated Ativan tablet 0.5 mg was to be administered by mouth once a day on Monday, Wednesday, and Friday before dialysis for the diagnosis of adjustment disorder with anxiety.</p> <p>Review of the Medication Administration Record (MAR), indicated Resident B had received Ativan 0.5 mg every Monday, Wednesday, and Friday from 3/10/25 to 5/28/25.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/25 at 1:42 P.M., the Administrator provided a policy titled, Psychotropic Management, dated 9/24, and indicated it was the current facility policy. The policy indicated, .It is the policy .to ensure that a resident's psychotropic medication regimen helps promote the resident highest practicable mental, physical, and psychosocial well-being .A psychotropic drug is any drug that affects the brain activities associated with mental process and behavior. These drugs include .Anti-anxiety [drugs] .Prior to initiating a psychotropic medication, and assessment by the .prescriber will be made of the resident including other potential causes of the behavior; as will as non pharmacological interventions that have been attempted. Symptoms and therapeutic goals must be clearly documented prior to initiating or increasing a psychotropic medication . diagnoses alone do not necessarily warrant the use [of] these medications .</p> <p>This citation relates to Complaint IN00460484.</p> <p>3.1-3(w)</p> <p>3.1-26(k)(l)(o)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive plan of care was created timely related to anit-anxiety medication use for 1 of 3 residents reviewed for care plans, (Resident B).</p> <p>Finding includes:</p> <p>During an interview on 6/18/25 at 10:20 A.M., the Memory Care Director indicated on 3/10/25, she was directed by the Director of Nursing to call the facility's Psychiatric Nurse Practitioner to request an order for medication to calm the resident while he received dialysis. The Memory Care Director indicated she had called and made the request to the Psychiatric Nurse Practitioner, who then prescribed Ativan 0.5 mg to be taken by mouth every Monday, Wednesday, and Friday before leaving the facility for dialysis.</p> <p>Resident B's clinical record was reviewed on 6/19/25 at 10:00 A.M. Diagnoses included but were not limited, Alzheimer's disease, vascular dementia, chronic kidney disease and adjustment disorder with anxiety.</p> <p>A physician's order, dated from 3/11/25 to 5/28/25, indicated Ativan tablet 0.5 mg to be administered by mouth once a day on Monday, Wednesday, and Friday before dialysis for the diagnosis of adjustment disorder with anxiety.</p> <p>Review of the Medication Administration Record (MAR), indicated Resident B had received Ativan 0.5 mg every Monday, Wednesday, and Friday from 3/10/25 to 5/28/25.</p> <p>The care plans for Resident B's included, but where not limited to, Psychotropic Drug Use, Resident is at risk for adverse side effects related to use of psychotropic medication-Anxiety, intitiated on 5/16/25.</p> <p>During an interview with the Assitance Director of Nursing, on 6/18/24 at 10:30 A.M., she indicated a care plan should have been initiated for Ativan use immediately after it was ordered but was not done.</p> <p>During an interview, on 6/18/25 at 11:00 A.M., with the Director of Nursing, she indicated a care plan should have been initiated for Ativan use, when the Ativan was prescribed, but was not done.</p> <p>On 6/17/25 at 1:42 P.M., the Administrator provided a policy titled Psychotropic Management, dated 9/24, and indicated it was the current facility policy. The policy indicated, .It is the policy .to ensure that a resident's psychotropic medication regimen helps promote the resident highest practicable mental, physical, and psychosocial well-being .Symptoms and therapeutic goals must be clearly documented prior to initiating or increasing a psychotropic medication .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to an article published by the National Library of Medicine, dated 4/10/23, regarding Care Planning and the Nursing Process, .Planning .is where goals and outcomes are formulated that directly impact patient care based on EDP [Evidenced Based Practice] guidelines. These patient-specific goals and the attainment of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs . Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum.</p> <p>This citation relates to Complaint IN00460484.</p> <p>3.1-35(a)</p>		