STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155806	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of Wabash	20 John Kissinger Drive Wabash, IN 46992

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the State Agency (Indiana Department of Health (IDOH)) for 1 of 3 residents reviewed for abuse. (Resident B)Findings include:Resident B's clinical record was reviewed on 6/3/26 at 9:14 a.m. Diagnoses included psychotic disorder with delusions due to known physiological condition and cognitive communication deficit. A 2/26/26, Significant Change, Minimum Data Set (MDS) assessment indicated Resident B was severely cognitively impaired.An Interdisciplinary Team note, dated 5/8/26 at 4:48 p.m., indicated a nurse heard another resident's family member kiss Resident B. Upon immediate assessment, the resident was not in any distress and was smiling. No injuries were noted. The resident appeared to be in pleasant mood and could not recall the incident. At the time of the occurrence, the visitor walked out of the building. A head-to-toe skin assessment completed revealed no adverse skin issues. The resident's daughter was contacted regarding the potential occurrence with no further concerns.A Facility Reported Incident submitted to the Indiana Department of Health, dated 5/8/26 at 4:13 p.m., indicated a staff member reported to the Director of Nursing (DON) that they heard a visitor (the son of another resident) kiss Resident B while he was visiting in her room. Staff intervened to remove the resident. The alleged visitor left the facility. A head-to-toe assessment was completed with no abnormal findings. The allegation was immediately reported to administration and an investigation was initiated. The resident was assessed for safety, well-being, and any concerns related to the incident. The resident was unable to state what happened but did not show signs of psychosocial distress and was smiling after the incident. Family and physician were notified of the incident. The preventative measures added on 5/8/26 indicated interviews with involved parties and witnesses were ongoing. Due to the nature of the allegation, the visitor was informed he was not permitted to return to the facility until the investigation was completed. The facility would continue to monitor the resident and take any necessary actions based on investigative findings. A police report was filed. Similar residents would be reviewed.A facility investigation summary related to Resident B, dated 5/7/26 at 9:00 p.m. and provided by the Administrator on 6/3/26 10:42 a.m., indicated the 200-hall nurse reported hearing a visitor kiss Resident B. Immediate action was taken to ensure the resident's safety. Staff were interviewed, the resident was interviewed, the physician was notified, Resident B's representative was notified, and the visitor was interviewed. Resident B had severe cognitive impairment. She had no pain and was unable to recall the event. The visitor indicated that he went to tell Resident B goodnight, and she asked him for a kiss. Resident B believed the visitor was her boyfriend, and the incident was not witnessed to know who initiated the kiss. The resident wanted the visitor to kiss her. The visitor kissed the resident per the resident's request, and the resident was not having psychosocial distress. The visitor was asked to leave pending investigation. The police were notified.During an interview, on 6/3/26 at 1:14 p.m., LPN 17 indicated, on 5/4/26, she heard a kissing sound, looked up, and saw a visitor walking away from Resident B. The visitor, who had a family member residing in the facility at that time, had previously sat with Resident B at lunch at times. LPN 17 assessed Resident B and notified the DON.During an interview, on 6/3/26 at 1:24 p.m., the Administrator, with the DON present, indicated (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the visitor was the son of a resident who was no longer at the facility. They reported the incident to the IDOH due to erroring on side of caution and the visitor's admission to kissing the resident. It was unclear who initiated the kiss. The facility conducted an investigation before reporting the incident to determine whether it needed to be reported to IDOH. LPN 17 reported the incident to the DON, and the DON reported it to the Administrator on 5/7/26 around 9:00 p.m. The incident occurred around shift change, and LPN 17 clocked out at 7:09 p.m. The incident was not reported due to not being 100% sure what had happened. The following day, the Administrator spoke with the visitor and reported it within the two-hour window of speaking with them.A current facility policy revised 10/24/22 titled Reportable Event Guidelines, provided by the Administrator, on 6/4/26 12:32 p.m., indicated the following: .Procedure.1. Occurrences to be reported include.2. The campus shall complete the appropriate State Reporting Form and send to the State Agency within the time set forth in state and federal guidelines.This Citation relates to Intake 3009804.410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement interventions to protect a resident pending the investigation of an allegation of abuse according to facility policy for 1 of 3 residents reviewed for abuse. (Resident B)Findings include:Resident B's clinical record was reviewed on 6/3/26 at 9:14 a.m. Diagnoses included psychotic disorder with delusions due to known physiological condition and cognitive communication deficit.A 2/26/26, Significant Change, Minimum Data Set (MDS) assessment indicated Resident B was severely cognitively impaired.During an interview, on 6/3/26 at 1:14 p.m., LPN 17 indicated, on 5/4/26, she heard a kissing sound, looked up, and saw a visitor walking away from Resident B. The visitor, who had a family member residing in the facility at that time, had previously sat with Resident B at lunch at times. LPN 17 assessed Resident B and notified the DON.During an interview, on 6/4/26 at 11:18 a.m., Activity Assistant 2 indicated Resident B's daughter came into the facility on 5/8/26 to discuss an incident involving a visitor who had kissed her mother the previous evening. Upon entering the facility, the daughter walked into the dining room and found Resident B and the visitor sitting together at a dining room table. Activity Assistant 2 indicated she had not been aware of the reported incident between the visitor and Resident B. Activity Assistant 2 immediately went to the dining room and observed Resident B and the visitor sitting across from each other at a table. She removed Resident B from the dining room and took her to the conference room, where she left the resident with her daughter, and then notified the Administrator. Activity Assistant 2 indicated that she may have previously seen Resident B and the visitor sitting in the dining room, but believed another person was also seated with them at that time. Resident B exhibited inappropriate behaviors, including wanting to kiss the male staff members, trying to hold their hands, or saying, he's [NAME]. Most of the time, Resident B was redirectable and just sought attention.During an interview, on 6/3/26 at 1:24 p.m., the Administrator, with the DON present, indicated the visitor was the son of a resident who was no longer at the facility. It was unclear who initiated the kiss. LPN 17 reported the incident to the DON, and the DON reported it to the Administrator on 5/7/26 around 9:00 p.m. The incident occurred around shift change, and LPN 17 clocked out at 7:09 p.m.During the exit conference, on 6/4/26 at 2:11 p.m., the Administrator, with the DON present, indicated that the kiss was not witnessed. A kissing sound was heard but could have been an air kiss. The Administrator was unable to make contact with the visitor and once he was in the building she interviewed him and confirmed the incident. The facility then restricted him from coming back into the facility at that time. A current facility policy revised on 12/16/24, titled Abuse, Neglect and Exploitation Procedural Guidelines, provided by the Administrator on 6/4/26 at 12:49 p.m. indicated the following: .Procedure.4. (e) Protection i. Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary.Cross reference F609.This citation relates to Intake 3009804.410 IAC (Indiana Administrative Code) 16.2-3.1-28(d)