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	01/14/2026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and interview, the facility failed to ensure required daily staffing information was accurately posted for residents, families, and the public by failing to include the facility census on daily staffing reports. This deficient practice had the potential to affect 51 of 51 residents by limiting residents, families, and the public from complete and accurate information regarding staffing levels in relation to the number of residents receiving care.Findings include:On 1/8/26 at 10:02 a.m., the facility's daily staffing report, located on the wall in the 100 hallway near the Social Services office, listed the number of nursing staff scheduled and/or working for each shift; however, the postings did not include the facility census for the corresponding date.On 1/9/26 at 1:33 p.m., the facility's daily staffing report did not include the facility census for the corresponding date.On 1/12/26 at 9:40 a.m., the facility's daily staffing report did not include the facility census for the corresponding date.On 1/13/26 at 8:39 a.m., the facility's daily staffing report did not include the facility census for the corresponding date.On 1/14/26 at 2:34 p.m., the facility's daily staffing report did not include the facility census for the corresponding date.During a review of Daily Staffing Reports from 12/2/25 through 1/13/25, provided by the Administrator on 01/14/2026 at 1:08 p.m., four reports included census information. The remaining 42 reports lacked census information.During an interview with the DON on 1/14/26 at 1:53 a.m., she indicated she was unaware the Daily Staff Reports lacked census information. The reports were automated and she was unsure why there was no census information included. The census was important because it would affect staffing requirements from one day to the next.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure medications were labeled with required information, including open dates, and failed to maintain medications in a secure and organized manner, as evidenced by loose medications found in a medication cart. This deficient practice had the potential to affect 51 of 51 residents. (Residents 9 and 42)Findings include: During an observation of the 200-hallway medication cart on [DATE] at 2:45 p.m., accompanied by QMA 3, a white round pill with the imprint TCL 340 and a yellow oblong pill with the imprint C55 were found loose in the second drawer from the top of the cart. QMA 3 indicated any loose medications found in the medication cart should be destroyed in the drug buster (a medication disposal system). Medication carts were cleaned out on an as needed basis. The 200-hallway medication cart stored medications for 39 of 51 residents.During an observation of the 100-hallway medication cart on [DATE] at 2:57 p.m., accompanied by RN 4, indicated the following:An unlabeled, prefilled, disposable insulin pen originally containing 300 units of insulin glargine contained approximately 20 units of remaining insulin. The lid of the insulin pen had a handwritten name in black ink (Resident 42) and an opened date of [DATE]. RN 4 indicated the date was either expired or possibly written incorrectly. The pen should have a resident label attached. The 100-hallway medication cart stored medications for 22 of 51 residents.An unlabeled, pre-filled, disposable insulin pen originally containing 300 units of insulin glargine contained approximately 25-30 units of remaining insulin. The lid of the insulin pen had a hand-written name (Resident 42) in black ink with no opened date. RN 4 indicated the pen should have a label and an opened date, but did not.A bottle of olopatadine solution 0.2% eye drops, with a label for Resident 42, lacked an opened date. RN 4 indicated eye drops should have opened dates written on the resident label.An unlabeled, pre-filled, disposable insulin pen, originally containing 300 units of insulin glargine contained approximately 150 units of remaining insulin. The lid of the insulin pen had a handwritten name in black ink (Resident 9) and an opened date of [DATE]. RN 4 indicated the pen itself should have a resident label attached.During an interview with the DON on [DATE] at 1:53 p.m., she indicated all medications should be labeled with the resident's name, ordering provider, date opened, and expiration date. The facility had blank labels which could be filled out with a pen and attached to each medication. Loose medications should be destroyed according to facility policy.A current facility policy, titled Medication Ordering, Receiving and Storage, provided by the Administrator on [DATE] at 1:02 p.m., indicated the following: .3. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. 4. If the facility has discontinued, outdated or deteriorated medications or biologicals, contact the dispensing pharmacy for instructions regarding returning or destroying these items.8. Medications shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications between residents.D. Check expiration date on package/container before administering any medications. When opening a multi-dose container, place the date on the container.Medications that cannot be returned to the dispensing pharmacy.will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances.3.1-25(j)(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store and prepare food under safe and sanitary conditions related to kitchen equipment and storage. This deficient practice had the potential to affect 92 of 92 residents who received food from the facility kitchen. Findings include:During a kitchen observation on 1/8/26 at 9:58 a.m., accompanied by the Dietary Manager, the following was observed:Upon entering the kitchen, numerous food splatters ranged from brown, black and red in color were on the floor in front of the doorway.Brown and black grease buildup was noted to the left side of the stove on the side of the steamer. Numerous grease streaks down the side of the steamer were honey brown and black in color.There were black and brown splatter marks all along the floor between the stove and the steam warmer. A whole top piece of a bun was laying face up between the stove and steamer.The bottom of the left oven had burnt-on, thick, black buildup. The buildup was the thickness of a pencil eraser.The oven face had a thick black grease streak that was the length of a piece of paper running down the front face of the stove to the left side of the griddle grease trap.Numerous grease streaks, from honey to white in color, ran down the right side of the griddle.The prep table in front of the stove had numerous pieces of food substance all over the storage shelves. The food substance ranged from pieces of shredded cheese to breadcrumbs all throughout the shelving. An open white plastic container, which stored pot lids, had a piece of dried egg, pieces of sausage, and shredded cheese in the container with the lids.The Dietary Manager indicated, at the time of observation, that the stove was cleaned weekly while the ovens were cleaned monthly. The floors should be swept nightly.During a kitchen observation on 1/14/26 at 8:39 a.m., the following was observed:Upon entering the kitchen, through the main dining room, numerous food substances were splattered on the floor. Food substances were honey color and black. A quarter-sized dark brown food substance was smeared on the floor.Near the door frame was dark red and light pink dried liquid on the floor.A splatter of a red food substance was seen at the backside of the prep table. Another red food splatter, which looked like smashed berries, was on the floor next to the wheeled bread cart. Numerous food particles were on the floor in front of the flour container.A yellow food substance, the size of a tennis ball, was dried on the floor next to the trash can by the hand-washing station.The oven face remained with a thick black grease streak, the length of a piece of paper, running down the front face of the stove to the left side of the griddle grease trap.The bottom of the left oven remained with a burnt-on, thick, black buildup. The buildup was the thickness of a pencil eraser.Numerous dark brown and black food splatters/ grease marks were on the floor between the stove, steamer and wall.The facility's weekly cleaning schedule indicated the chargrill and ovens were cleaned on Tuesdays, the prep areas and tables were cleaned on Wednesdays, and the stove range was cleaned on Thursdays.The PM aide cleaning list indicated to wipe down all surfaces and counter tops.The PM [NAME] Cleaning list indicated to clean inside and outside of the oven, clean the stop tip and flat top, clean grill grates, wipe down outside, and change foil.The AM aide cleaning list indicated to wipe down all surfaces and counter tops.A December 2025 plan of correction audit indicated, on December 23, 27, and 31 (2025), all areas were compliant.A December 2025 cleaning log was reviewed, on 1/14/25, which indicated on December 24, 27, and 31st, two to three corrections were needed.A current facility policy, dated 2/8/18, titled Kitchen Equipment Preventative Maintenance, provided by the Administrator, on 1/14/26 at 1:19 p.m , indicated the following: .Ranges: check that burner tops are cleaned appropriately; Fryers: Make sure it is free of oil build up internally 3.1-21 (i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview, observation, and record review, the facility failed to ensure infection prevention and control strategies for transmission-based precautions were followed for 1 of 3 residents reviewed for contact isolation precautions. (Resident 1) Findings include:During an interview, on 1/8/26 at 11:26 a.m., Resident 1 indicated she was unable to recall what type of infection she had. An enhanced barrier precaution (EBP) sign was located under the nameplate of Resident 1's room. A personal protective equipment (PPE) cart was in her room beside the door. During an observation, on 1/8/26 at 3:03 p.m., the EBP sign was no longer present. A contact precautions sign hung above Resident 1's nameplate.During an observation, on 1/12/26 at 2:44 p.m., a large, empty, cardboard biohazard box sat beside the PPE cart in Resident 1's room. During an interview, on 1/12/26 at 3:01 p.m. LPN 6 indicated Resident 1 had been on contact isolation for COVID-19. An EBP sign had been placed in error after the resident was out of COVID-19 precautions. Resident 1 had a qualifying condition that fell under the EBP category; however the contact isolation should have stayed in effect due to Resident 1 having had a lengthy history and current diagnosis of Clostridium difficile (C. diff). EBP was used during hands-on care and contact precautions was used during any contact with the resident, her belongings, or anything in the resident's room. Soap and water were to be used when hand hygiene was performed by the staff and the resident. Staff were to assist the resident with hand hygiene. The resident had bowel incontinence and was able to leave her room if her bowel movements were contained. During an observation, on 1/13/26 at 10:45 a.m., Physical Therapist 7 knocked on Resident 1's door, greeted the resident, and indicated he was there to take her to therapy. He retrieved Resident 1's gait belt and assisted Resident 1 out of her room via her wheelchair. As he held the gait belt in his left hand, he grasped the wheelchair handles with both bare hands and propelled the resident to the therapy room. Neither he nor the resident utilized PPE or performed hand hygiene upon entering or exiting the resident's room. In the therapy room, the therapist placed the gait belt around Resident 1's waist and placed a walker in front of the resident. The resident grasped the walker hand grips and began to ambulate. Once therapy was completed, the therapist removed the gait belt and sat the walker off to the side with other equipment. The therapist returned Resident 1 to her room via wheelchair and placed the gait belt back in the resident's room. The therapist exited Resident 1's room without performing any type of hand hygiene. During an interview, on 1/13/26 at 10:52 a.m., Physical Therapist 7 indicated the contact precaution sign was for the nursing staff who performed wound care and provided personal care. He usually wore gloves. No hand hygiene was performed by him or the resident. Hand hygiene was a task worked on by occupational therapy and he was in physical therapy. During an interview, on 1/13/26 at 11:06 a.m., QMA 8 indicated Resident 1 could not toilet herself. Resident 1's hands needed to be washed with soap and water after toileting due to the resident having C. diff (Clostridioides difficile) (highly contagious bacterium that causes diarrhea and bowel inflammation). During an interview, on 1/13/26 at 11:10 a.m., Housekeeper 9 indicated she cleaned Resident 1's room once a day. She used a disinfectant light with each cleaning. She wore gloves when she cleaned Resident 1's room and performed hand hygiene by either washing her hands with soap and water or with hand sanitizer. During an observation, on 1/13/26 at 5:01 p.m., CNA 10 entered Resident 1's room, moved items so she could get behind Resident 1's wheelchair, and grasped the wheelchair handles bare handed. She propelled Resident 1 to the DR. No PPE was utilized nor was hand hygiene performed by either the resident or staff member upon entering or exiting Resident 1's room. CNA 10 assisted Resident 1 to a dining room table. She walked over to a neighboring dining room, without washing her hands, retrieved a ceramic coffee cup, filled the with coffee, and took it to Resident 1. CNA 10 indicated she did not wash her (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands and should have, because Resident 1 had a bacterial infection. By not washing her or Resident 1's hands the disease could spread to others. Resident 1 had been in isolation three times since her admission to the facility. Resident 1 needed assistance with toileting and continued to have loose stools. A gown, mask, and gloves were to be worn when personal care was given and when personal items were touched. During an interview, on 1/14/25 at 9:57 a.m., the Infection Preventionist indicated contact precautions were utilized when a resident had C.diff or Methicillin-resistant Staphylococcus aureus (MRSA) (an antibiotic-resistant infection). Transmission based precautions were utilized for residents who had COVID-19. EBP was for residents who had a PICC line (peripherally inserted central catheter), urinary catheter, or had wounds. Staff were educated at the time isolation was put into place and education was based on a resident's diagnosis. The majority of education was provided to the nursing staff due to other departments did not perform hands-on care. The whole building was educated. She was not sure why Resident 1's EBP sign was switched to the contact precaution sign. Resident 1 was admitted with C.diff and probably should have had remained on contact precautions the whole time. The EBP sign was put into place due to Resident 1 having a wound. Resident 1's clinical record was reviewed on 1/14/25 at 11:32 a.m. Diagnoses included Enterocolitis (inflammation of the small intestine) due to Clostridioides difficile, not specified as recurrent, and 2019-nCoV acute respiratory disease (COVID-19). Current orders included vancomycin (antibiotic)125 milligrams (mg) by mouth daily every three days (12/31/25), probiotic blend 2 billioncell (supplement) 50 mg by mouth twice a day (12/2/25), contact precautions, special instructions: C-diff, every shift (1/9/26), and staff to use enhanced barrier precautions, wearing a gown and gloves at minimum during high-contact care activities, every shift (12/30/25). A significant change Minimum Data Set (MDS) assessment, dated 12/10/25, indicated Resident 1 had severe cognitive impairment. She was independent in eating. She needed supervision or touching assistance with oral hygiene and was dependent in toileting hygiene, shower/bathing, footwear, sit to stand, chair/bed to chair transfers, and toilet transfers. Resident 1 was frequently incontinent of her bowels and bladder. A current care plan, dated 12/31/25, indicated Resident 1 required enhanced barrier precautions (EBP) during high-contact care related to presence of C.diff. Interventions included the following: apply, remove, and dispose of PPE systematically and appropriately, per policy, face mask to be utilized as needed, observe for and report any new or worsened signs and symptoms of infection, perform hand hygiene before and after care, per policy and as required, utilize gown and gloves per EBP policy during high contact ADL care (dressing, showering/bathing, hygiene, transfers, toileting/changing briefs) and during linen changes, (12/31/25). A current care plan, dated 11/19/25, indicated Resident 1 had a gastrointestinal infection: C-Difficile. Interventions included the following: administer medications and treatments as ordered, evaluate, report, and record effectiveness, and any adverse side effects, assess for the potential cause of, precipitating and aggravating factors to episodes of nausea, vomiting and diarrhea, notify physician as appropriate, isolation precautions per policy, record the duration and frequency of diarrhea and or emesis; characteristics, consistency, and quantity (11/19/25). A progress note, dated 10/24/25 at 11:19 a.m., recorded as a late entry on 10/25/25 at 11:45 a.m., indicated Resident 1 was admitted to the facility following a hospital stay. Admitting diagnosis included a urinary tract infection and C. diff. The resident was on oral vancomycin. The resident was incontinent of bowel and bladder and did have loose, liquid stool with mucous present. A progress note, dated 10/29/25 at 4:03 p.m., indicated Resident 1 continued to take an antibiotic for C-diff and had diarrhea. A progress note, dated 11/3/25 at 11:28 a.m., indicated isolation precautions were discontinued for Resident 1 due to oral vancomycin was completed on 10/31/25 and the resident's stool was formed. A physician progress (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note, date 11/17/25 at 1:31 p.m., recorded as a late entry on 11/19/25 at 1:36 p.m., indicated Resident 1 had increased abdominal discomfort and cramping. Stools were loose and watery. Resident 1 had brief improvement regarding stools but loose stools returned. Stool sample results were pending for C.diff. A progress note, dated 11/18/25 at 3:05 p.m., indicated Resident 1's stool sample tested positive for C .diff. New orders were received to place the resident on contact precautions and start vancomycin 125 mg by mouth four times a day for ten days. A skilled nurses note, dated 11/23/25 at 4:21 p.m., indicated Resident 1 required EBP and isolation precautions. A progress note, dated 12/1/25 at 10:24 p.m. indicated Resident 1 remained in isolation, started a probiotic, and an order was received to check stool for C. diff. An interdisciplinary team (IDT) note, dated 12/1/25 at 2:33 p.m., indicated Resident 1 had completed antibiotics for C. diff and the resident continued to have soft, liquid stools. A progress note, dated 12/2/25 at 3:43 p.m., indicated Resident 1's lab results were positive for C. diff. A progress note, dated 12/3/25 at 3:46 p.m., indicated Resident 1 required contact and isolation precautions. A progress note, dated 12/10/25 at 5:50 p.m., indicated Resident 1 continued to have frequent, loose, unformed stools. An Interdisciplinary team (IDT) note, dated 12/15/25 at 10:10 p.m., indicated Resident 1 continued on an antibiotic for C. diff and continued to have multiple loose, soft stools per day. A physician progress note, dated 12/23/25 at 12:31 p.m., indicated Resident 1 continued with abdominal discomfort and loose bowel movements. A physician note, dated 12/26/25 at 12:52 p.m., indicated Resident 1 tested positive for COVID-19 and was on isolation per facility protocol. A progress note, dated 12/31/25 at 6:30 p.m., indicated Resident 1 was in isolation for COVID-19. Resident continued on antibiotic for C. diff and had loose stools with foul odor. A progress note, dated 1/4/26 at 1:00 a.m., indicated Resident 1 had a second negative COVID-19 test in 48 hours and COVID-19 isolation orders were discontinued. A progress note, dated 1/4/26 at 12:03 p.m., indicated Resident 1 did not need isolation precautions. A provider progress note, dated 1/6/26 at 1:19 p.m., indicated Resident 1 continued to have loose stools and was receiving refractory (not responding to antibiotics) treatment for C.diff. A progress note, dated 1/8/26 at 9:03 p.m., indicated Resident 1 did not need isolation precautions. A progress note, dated 1/9/26 at 11:37 a.m., indicated Resident 1 had C. diff precautions in place and new orders were received for vancomycin (antibiotic). A progress note, dated 1/14/26 at 1:29 a.m., indicated Resident 1 continued on precautions for C. diff. A skilled progress note, dated 1/14/26 at 2:40 a.m., indicated no isolation precautions were needed. During an interview, on 1/14/26 at 12:10 p.m., LPN 12 indicated the facility staff were to wear gowns and gloves when entering Resident 1's room and were to wash hands with soap and water when entering and exiting the room. Resident 1 required staff assistance with toileting needs and she was incontinent of bowel at times. Staff were to assist Resident 1 with washing her hands with soap and water. During an interview, on 1/14/26 at 1:53 p.m., the DON indicated if a resident was on contact isolation, a sign should be on the door. If contact was made with a resident on contact isolation the staff were to wear a gown, gloves, mask, and face or eye protection if there was a risk of splashing. Proper hand hygiene was to be done. If caring for a resident with C. diff, soap and water were to be used. No alcohol-based sanitizer was to be used for residents with C .diff but would be acceptable for residents with COVID-19. Staff were made aware verbally of any resident on isolation and of any precautions that were to be taken. All facility departments were notified and each department had their own daily huddle where they passed the information along to their staff, such as if a resident was on isolation or had C. diff. Resident 1 was able to keep loose stools contained, so she was allowed to move about the facility. The precaution signs were changed on Resident 1's entryway due to confusion as to which sign(s) were appropriate. Facility staff were receiving (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	re-education regarding isolation and hand hygiene. During an interview, on 1/14/26 at 1:53 PM, the Clinical Support Specialist indicated contact precautions were to protect the staff, meaning a resident on contact precautions had a diagnosis that could spread to others, whereas EBP protected the resident from staff. Resident 1 had a qualifying diagnosis for both EBP and contact isolation. Resident 1 had orders for contact isolation orders prior to the contact precaution sign being posted. When Resident 1's COVID-19 droplet precautions were discontinued, staff removed the contact precaution sign and left the EBP sign in place. A current facility policy, revised on 11/15/21, titled Infection Prevention and Control Program (IPCP), provided by the Administrator on 1/8/26 at 3:23 p.m., indicated the following: Purpose Statement: The purpose of this policy is to: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.2.a. Reviews and adopts the corporates Infection Prevention and Control guidelines recommending additions or revisions as necessary (Hand Hygiene, Standard Precaution, Contact Precautions, etc). Reviews policies and procedures annually. b. Surveillance activities to identify, investigate, control, and prevent the spread of infection. Infections should be tracked per hall/unit, type of infection, and monitor lab reports to identify organism(s).d. Evaluates implementations and effectiveness of recommended actions. e. Monitors compliance with infection control practices and procedures. A current facility policy, revised on 2/28/24, titled Guidelines for Contact Precaution , provided by the Administrator on 1/14/26 at 1:02 p.m., indicated the following: Purpose Statement: The purpose of this policy is to: To provide guidelines to prevent the spread of infectious disease organisms. Policy: Guidelines for Contact Precautions. Procedure: 1. Contact Precautions is a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods. a. Direct contact transmission involves skin to skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized resident.b. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the resident's environment. 2. Contact Precautions are indicated to prevent and control HAI (health-care associated infections) transmission of infection with any of the following: b. clostridium difficile.5. Personal Protective Equipment: a. Wear gloves before contact with the resident or environmental objects. Change gloves and wash hands after having direct contact with the resident, possible infective material, or potentially contaminated environmental objects in between each resident care intervention.6. Precaution Sign: a. Post a sign at the resident's door that is appropriate according to CDC guidance. 3.1-18 (a)3.1-18 (l)