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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of South Bend	52565 State Road 933 South Bend, IN 46637

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48145 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 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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-3(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49229 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. 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., 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49229 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: 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)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 44111 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 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 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 .

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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. 44111 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 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)