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	04/20/2026

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's dignity was maintained related to a staff member making a disrespectful comment to a resident for 1 of 1 resident reviewed for dignity. The deficient practice was corrected on 2/21/26, prior to the start of the survey, and was therefore past noncompliance. (Resident 34)Finding includes: An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 2/14/26, indicated a family member of Resident 34 came to visit, and as he was walking up to the resident, he overheard CNA 5 telling her to shut up. The resident was moved to a safe place, and the CNA was suspended and escorted out of the building pending an investigation. On 4/14/26 at 11:30 a.m., Resident 34 was observed seated in her wheelchair near the nurse's station. The resident was talking to herself, leaning over in her chair and fidgeting. On 4/14/26 at 3:32 p.m., the resident was observed in her recliner in her room. Her feet were elevated and her eyes were closed. The resident was confused and unable to understand or answer questions during the survey. Resident 34's record was reviewed on 4/15/26 at 10:00 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, disorientation and fracture of the femur neck.The admission Minimum Data Set assessment, dated 2/10/26, indicated the resident had significant cognitive impairment, a history of falls and required partial to moderate assistance for bed mobility, toileting and transfers.The facility investigation into the allegaton included interviews with staff, the family member and employee. The allegation of inappropriate language was substantiated, and the CNA was terminated and reported to the Nurse Aide Registry. All staff were in-serviced on Abuse, Neglect, and Exploitation Guidelines and Preventing, Recognizing and Reporting Abuse and Neglect between 2/16/26 and 2/21/26. During an interview on 4/17/26 at 10:35 a.m., the Administrator indicated following an allegation, the resident's safety is maintained and the accused employee is immediately suspended pending the investigation. All parties are notified and the incident is reported to the State. In this case, the son had called to report the incident to the Administrator, and the employee had ultimately been terminated. The resident had no effects related to the incident. All staff had been in-serviced on abuse and reporting. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure a resident's legal guardian was informed of a change in treatment related to psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 7) Finding includes: Resident 7's record was reviewed on 4/14/26 at 3:53 p.m. Diagnoses included, but were not limited to, schizophrenia and dementia.The Quarterly Minimum Data Set assessment, dated 3/5/26, indicated the resident was cognitively intact. She received antipsychotic medications.A Guardianship Form, dated 2/17/21, indicated Resident 7 was adjudicated as an incapacitated person and was appointed a guardian by the court.A Physician's Order, dated 10/2/25, indicated Haldol (an antipsychotic medication) 1 milligram (mg) daily and 1 mg at bedtime.A Physician's Order, dated 3/4/26, indicated Haldol 2 mg in the morning and 3 mg at bedtime.A Psychotropic Medication Informed Consent Observation, dated 3/5/26 at 12:27 p.m., indicated the resident had an increase in psychotropic medication dose, the medication class was an antipsychotic. The increased medication was Haldol 2 milligrams (mg) every morning and 3 mg every evening. The consent was signed by the resident.The record lacked any documentation the resident's legal guardian was informed or consent obtained when the antipsychotic medication had been increased.During an interview on 4/17/26 at 11:50 a.m., the Director of Nursing indicated the guardian should have been notified and signed the consent. The resident had a BIMS score of 14 and the guardian was aware she was taking antipsychotic medications. Both the guardian and the resident had agreed about taking the antipsychotic medication.A facility policy titled, Psychotropic medication use and gradual dose reduction guidelines, indicated, .2. A consent must be obtained by the Resident/Responsible Party prior to initiating a new psychotropic medication, increasing the dose of a psychotropic medication, or changing a current psychotropic medication to an alternate psychotropic medication . 410 IAC (Indiana Administrative Code) 16.2-3.1-3(n)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to medications not administered as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 30) The facility also failed to ensure physician's orders were followed related to a resident's compression wraps for 1 of 2 residents reviewed for edema. (Resident 7) Findings include:1. Record review for Resident 30 was completed on 4/14/26 at 3:26 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, and orthostatic hypotension. A Physician's Order, dated 3/26/26, indicated to give midodrine (medication to increase your blood pressure) 10 milligrams (mg) three times a day. Hold for systolic blood pressure (SBP, top number of blood pressure reading) greater than 130. The April 2026 Medication Administration Record (MAR) indicated the midodrine was not administered when the blood pressure (BP) was in parameters or administered when the BP was out of parameters on the following dates and times:-4/1/26 at 6:00-8:00 a.m., the BP was 102/51 and the midodrine was not administered -4/1/26 at 12:00-1:00 p.m., the BP was 122/74 and the midodrine was not administered-4/6/26 at 6:00-8:00 a.m., the BP was 116/72 and the midodrine was not administered-4/6/26 at 12:00-1:00 p.m., the BP was 138/77 and the midodrine was administered During an interview on 4/16/26 at 10:17 a.m., the Director of Nursing (DON) indicated the nurse had read the order wrong and should have administered the medication when the BP was below 130 and held the medication when the BP was over 130. 2. During a random observation on 4/17/26 at 9:44 a.m., Resident 7 was in bed. Her legs were uncovered. She did not have any type of compression wraps or socks on at the time. Her legs appeared to be swollen. The resident indicated she had not been helped with getting up and out of bed yet. On 4/17/26 at 11:00 a.m., Resident 7 was observed being propelled down the hallway. She was wearing non-slip socks on both feet. On 4/17/26 at 3:34 p.m., Resident 7 was sitting in a wheelchair in the main lobby/gathering area during activities. She was wearing non-slip socks on both feet. Resident 7's record was reviewed on 4/14/26 at 3:53 p.m. Diagnoses included, but were not limited to, chronic kidney disease and localized edema. A Care Plan, dated 8/19/21, indicated the resident received diuretic medications related to edema (swelling) and hypertension. An intervention was to apply Tubigrips (compression bandage) to bilateral lower extremities as ordered. A Physician's Order, dated 10/1/24, indicated apply compression wrap (Tubigrip) from mid-foot to knee, covering the heel. Apply in the morning and remove at bedtime. The April 2026 Medication and Treatment Administration Record indicated the Tubigrips were marked as administered on 4/17/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set assessment, dated 3/5/26, indicated the resident was cognitively intact. During an interview on 4/17/26 at 3:34 p.m., the Assistant Director of Nursing was notified and had no further information to provide. 410 IAC (Indiana Administrative Code) 3.1-16.2-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed to ensure pressure ulcer treatment was provided as ordered for 1 of 2 residents reviewed for pressure. (Resident 9)Finding includes: Resident 9's record was reviewed on 4/14/26 at 2:14 p.m. Diagnoses included, but were not limited to, Sezary disease (a blood cancer affecting the skin) and severe protein calorie malnutrition. The admission Minimum Data Set assessment, dated 4/11/26, indicated the resident had moderate cognitive deficits and received hospice care.A wound assessment, dated 3/26/26, indicated the resident had a deep tissue injury (DTI, pressure injury) to his right heel. A Physician's Order, dated 4/11/26, indicated to gently cleanse and dry the right heel, apply skin prep to the surrounding wound. Collagen to the wound bed, Xeroform to the wound and wrap with Kerlix every Monday, Wednesday, and Friday. On 4/15/26 at 3:10 p.m., the Wound Nurse was observed performing the wound treatment to the resident. She washed the wound with wound cleanser and patted dry, she then applied the collagen and Xeroform to the wound bed and wrapped the heel with Kerlix. She did not apply skin prep to the surrounding skin. During an interview on 4/15/26 at 3:56 p.m., the Wound Nurse indicated she did not apply the skin prep as ordered. 410 IAC (Indiana Administrative Code) 16.2-3.1-40

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure fall interventions were care planned for and/ or in place for a resident with a history of falls for 1 of 1 resident reviewed for accidents. (Resident 34)Finding includes: Resident 34's record was reviewed on 4/15/26 at 10:00 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, disorientation and fracture of the femur neck.The admission Minimum Data Set assessment, dated 2/10/26, indicated the resident had significant cognitive impairment, a history of falls and required partial to moderate assistance for bed mobility, toileting and transfers.An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 2/27/26, indicated the resident was attempting to ambulate in her room and sustained a fall. The resident was transported to the hospital for evaluation and found to have a fracture of her left femoral neck. Upon return, care plans were updated. The Fall Care Plan, dated 2/5/26, indicated the resident was at risk for falls. Interventions included, but were not limited to, do not transfer to recliner chair. The care plan was updated on 3/9/26 to include a ghost alarm to the wheelchair and mattress (an alarm that signals at nurse's station). There was no intervention that included use of a floor mat. On 4/14/26 at 11:30 a.m., Resident 34 was observed seated in her wheelchair near the nurse's station. The resident was talking to herself, leaning over in her chair and fidgeting. A staff member was seated at the nurse's station and CNA 2 was standing a few feet away. The resident continued to fidget, it was then observed the resident's buttocks were coming over the edge of the wheelchair seat. The CNA was immediately notified, she ran to the resident and caught her as she slipped out of the wheelchair. The resident said she was trying to go to the bathroom. The CNA took her to her room at that time. No alarm had sounded at any time during the observation. On 4/14/26 at 3:32 p.m., the resident was observed in her recliner in her room. Her feet were elevated and her eyes were closed. There was a floor mat in the room propped up against the dresser. During an interview on 4/15/26 at 3:04 p.m., CNA 1 indicated fall interventions for the resident included bed and chair alarms, keep the bed in low position and keeping her in sight. Also, put a mat on the floor or next to the recliner when she was sleeping. During an interview on 4/15/26 at 3:33 p.m., the Director of Nursing and Nurse Consultant were made aware of the near fall and that the alarm had not activated. They were also made aware the floor mats had not been care planned and the resident was not to be put in the recliner. They indicated they would look into the issues. No further informaton was received. During an interview on 4/17/26 at 11:47 a.m., CNA 2 indicated the ghost alarm had been on the wheelchair when the resident had a near fall on 4/14 but did not know why the alarm didn't activate. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)

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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 observation, record review and interview, the facility failed to ensure infection control guidelines were followed related to a nurse touching a resident's medications with ungloved hands during a medication pass observation for 1 of 5 residents observed during medication pass. (Resident 59, LPN 1)Finding includes: On 4/16/26 at 10:09 a.m., LPN 1 was observed preparing Resident 59's medications. She indicated the spironolactone (a diuretic) was going to be held because the resident's blood pressure was below the ordered parameters. She tore open the plastic pouch that contained four tablets and poured them into her ungloved hands. She picked up each pill and placed it in a medicine cup, then she picked up the spironolactone and disposed of it. She then gave the resident his pills. During an interview immediately following, the LPN was made aware she had handled the resident's pills with ungloved hands. There was no additional information provided.During an interview on 4/16/26 at 11:50 a.m., the Clinical Support Nurse and Director of Nursing were made aware of the observation. They indicated the nurse should have worn gloves if touching the pills. The policy, Specific Medication Administration Procedures, revised 11/18, indicated, .Procedures .C. For Solid medications: 1) Pour or push the correct number of tablets or capsules into the souffle cup, taking care to avoid touching the tablet or capsule, unless wearing gloves 410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)