

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K010000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/19/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/08/14</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Brett Overmyer, Life Safety Code Specialist.</p> <p>At this PSR survey, West Bend Nursing and Rehabilitation was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 01 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222)</p>	K010000	K010000 The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
---------	---	---------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 177 and had a census of 100 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/10/14.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/08/2014	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010038 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation, interview and record review: the facility failed to ensure exit access was arranged so 1 of 2 exits from the main dining room was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect any resident, staff or visitor using the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010038	<p>K038 – A quote has been acquired by the facility for a local contractor to complete concrete work in order to create the proper means of egress from the main dining room to the public way.</p> <p>In order to ensure compliance the work will be completed in the second quarter of 2014 due to weather restrictions.</p> <p>All means of egress will be monitored during routine preventative maintenance for 6 months. This will be reviewed as part of the CQI process.</p> <p>All residents have the potential to be affected. The Maintenance Supervisor or designee will record their findings on the “Means of Egress” auditing tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.</p> <p>The work will be completed by May 8, 2014. Systemic changes will be completed by May 8, 2014.</p>	05/08/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>Maintenance Supervisor on 04/08/14 from 10:00 a.m. to 11:00 a.m., the secondary exit from the main dining room to the exterior was provided with a concrete stoop outside the door but the means of egress from the main dining room did not terminate at a public way. This was acknowledged by the Maintenance Supervisor at the time of observation. Based on record review and interview at the time of observation, the Maintenance Supervisor acknowledged the main dining room means of egress did not terminate at a public way, and provided documentation of a contract in place to add a means of egress to the public way when weather allows.</p> <p>This deficiency was cited on 04/08/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/08/2014	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010061 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation, record review and interview; the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 10:00 a.m. to 11:00 a.m., on 04/08/14, the Post Indicator Valve (PIV) outside the facility near the laundry lacked electronic supervision. Based on record review and interview at the time of observation, the Maintenance Supervisor acknowledged the PIV lacked electronic supervision and provided documentation of a contract in</p>	K010061	<p>K061 – A local contractor will electronically tie in the Post Indicator Valve to an electronic monitoring system in order to monitor for the integrity of the system. The work will be completed prior to the end of the second quarter of 2014.</p> <p>All residents have the potential to be affected. The Maintenance Director or designee will monitor this system monthly for 6 months. The system will be reviewed as part of the CQI program.</p> <p>The Maintenance Director or designee will record the results of the audit on the "PIV Monitoring" tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.</p> <p>Systemic changes will be completed by May 8, 2014.</p>	05/08/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>place to add electronic supervision when weather allows.</p> <p>This deficiency was cited on 04/08/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K020000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/19/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/08/14</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Brett Overmyer, Life Safety Code Specialist.</p> <p>At this PSR survey, West Bend Nursing and Rehabilitation was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 02 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222)</p>	K020000	K010000 The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
---------	---	---------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 177 and had a census of 100 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 04/08/2014	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K020061 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation, record review and interview; the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 10:00 a.m. to 11:00 a.m. on 04/08/14, the Post Indicator Valve (PIV) outside the facility near the laundry lacked electronic supervision. Based on record review and interview at the time of observation, the Maintenance Supervisor acknowledged the PIV lacked electronic supervision and provided documentation of a contract in</p>	K020061	<p>K061 – A local contractor will electronically tie in the Post Indicator Valve to an electronic monitoring system in order to monitor for the integrity of the system. The work will be completed prior to the end of the second quarter of 2014.</p> <p>All residents have the potential to be affected. The Maintenance Director or designee will monitor this system monthly for 6 months. The system will be reviewed as part of the CQI program.</p> <p>The Maintenance Director or designee will record the results of the audit on the "PIV Monitoring" tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.</p> <p>Systemic changes will be completed by May 8, 2014.</p>	05/08/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>place to add electronic supervision when weather allows.</p> <p>This deficiency was cited on 04/08/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 04/08/2014	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K030000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/19/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/08/14</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist and Brett Overmyer, Life Safety Code Specialist.</p> <p>At this PSR survey, West Bend Nursing and Rehabilitation was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 03 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222)</p>	K030000	K010000 The Creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 177 and had a census of 100 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 04/08/2014
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K030061 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation, record review and interview; the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor from 10:00 a.m. to 11:00 a.m. on 04/08/14, the Post Indicator Valve (PIV) outside the facility near the laundry lacked electronic supervision. Based on record review and interview at the time of observation, the Maintenance Supervisor acknowledged the PIV lacked electronic supervision and provided documentation of a contract in</p>	K030061	<p>K061 – A local contractor will electronically tie in the Post Indicator Valve to an electronic monitoring system in order to monitor for the integrity of the system. The work will be completed prior to the end of the second quarter of 2014.</p> <p>All residents have the potential to be affected. The Maintenance Director or designee will monitor this system monthly for 6 months. The system will be reviewed as part of the CQI program.</p> <p>The Maintenance Director or designee will record the results of the audit on the "PIV Monitoring" tool. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.</p> <p>Systemic changes will be completed by May 8, 2014.</p>	05/08/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>place to add electronic supervision when weather allows.</p> <p>This deficiency was cited on 04/08/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			
--	--	--	--	--