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	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/25/23 Facility Number: 013302 Provider Number: 155824 AIM Number: 201281730 At this Emergency Preparedness survey, Wellbrooke of South Bend was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 70 and had a census of 49 at the time of this survey. Quality Review completed on 01/30/23	E 0000	Preparation or execution of this plan of correction by Wellbrooke of South Bend does not constitute admission or agreement with the truth of the facts alleged in the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of the Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Survey on January 25, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance. With this, we the provider respectfully request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/25/23 Facility Number: 013302 Provider Number: 155824	K 0000	Preparation or execution of this plan of correction by Wellbrooke of South Bend does not constitute admission or agreement with the truth of the facts alleged in the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cassie Dunlap	Area Executive Director	02/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	AIM Number: 201281730 At this Life Safety Code survey, Wellbrooke of South Bend, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a horizontal floor/ceiling assembly with a 2-hour Fire Resistive Rating. The rated floor/ceiling system is supported by 2 hour rated construction. The Southwest wing of the first floor is a residential occupancy, however is not separated from the healthcare facility by a 2-hour fire barrier, and is therefore surveyed as healthcare. The building is partially protected by a 300 kW natural gas powered generator. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 49 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/30/23		Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Life Safety Code with Emergency Preparedness Survey on January 25, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance. With this, we the provider respectfully request a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms in the private dining area of the main lobby with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This	K 0321	**1- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	02/14/2023

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	deficient practice could affect 20 staff and residents in the dining area. Findings include: Based on observation during a tour of the facility with Maintenance Director on 01/25/23 between 1:18 p.m. and 3:15 p.m., the private dining storage room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		There were no negative outcomes for this alleged deficient practice. The private dining room has been cleared of all storage. **2- How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** Residents near or in the dining room had the potential to be affected by the alleged deficient practice. **3- What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Director of Plant Operations was educated by the Executive Director on K-321 – Hazardous Areas - Enclosure. The storage was removed and meets the conditions of NFPA 101. This space is now empty and will be utilized as a private dining area (see attached picture). The Executive Director and/or designee will audit to ensure there is no further storage placed in this area. **4- How the corrective action(s) will be monitored to ensure the deficient practice will no longer recur?** Weekly audits will be conducted for 4 weeks, then bi-weekly for 4	

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			weeks, then monthly audits will be conducted for 2 months and reviewed by QA for a minimum of 6 months.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to maintain 1 of 1 kitchens in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011. NFPA 96, Section 12.1.2.4 states all deep-fat fryers shall be installed with at least a 406 mm (16 in.) space between the fryer and surface flames from adjacent cooking equipment. Section 12.1.2.5 states where a steel or tempered glass baffle plate is installed at a minimum 203 mm	K 0324	**1- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** There were no negative outcomes for this alleged deficient practice. The protective shield/baffle plate was located and installed.	02/14/2023

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	(8 in.) in height between the fryer and surface flames of the adjacent appliance, the requirement for a 406 mm (16 in.) space shall not apply. This deficient practice could affect all residents in the dining room/kitchen area. Findings include: Based on an observation with the Maintenance Director on 01/25/23 between 1:18 p.m. and 3:15 p.m., the deep fat fryer was located 6 inches from the gas burners on the commercial cooking stove and did not have a protective shield measuring at least eight inches in height between the two appliances. The measurement was provided by the surveyor. Upon interview at the time of observation, the Maintenance Director stated that they had a baffle plate, but needed to locate it for installation. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**2- How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** No residents had the potential to be affected by this alleged deficient practice. **3- What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Director of Plant Operations was educated by the Executive Director on K-324 – Cooking Facilities. The protective shield was installed (see picture) and meets the conditions of NFPA 101. The Executive Director and/or designee will continue audits to ensure the protective shield remains in place. **4- How the corrective action(s) will be monitored to ensure the deficient practice will no longer recur?** Weekly audits will be conducted for 4 weeks, then bi-weekly for 4 weeks, then monthly audits will be conducted for 2 months and reviewed by QA for a minimum of 6 months.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on observation and interview, the facility failed to ensure 4 of 12 sprinkler heads in the kitchen were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect kitchen staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/25/23 between 1:18 p.m. and 3:15 p.m., four sprinkler heads located near the cooktop grills and	K 0353	**1- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** There were no negative outcomes for this alleged deficient practice. The sprinkler heads were cleaned and the ceiling tiles were replaced. **2- How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** No residents had the potential to be affected by this alleged deficient practice. **3- What measures will be put into place and what systemic changes will be made to ensure that the deficient**	02/14/2023

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	dishwashing station showed signs of accumulated dirt and lint which covered the colored bulb on the sprinkler head, Upon interview at the time of observation, the Maintenance Director acknowledged the dirty sprinkler heads and would contact the contracted entity for service. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 private dining area. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 5 dining room residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 03/01/22 at 1:50 p.m., in the suspended ceiling the private dining area, there were four ceiling tile missing and exposed the ceiling about one to two feet above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there were missing ceiling tiles and exposed the ceiling above the drop ceiling. The finding was reviewed with the Administrator and Maintenance Director during the exit		**practice does not reoccur?** The Director of Plant Operations was educated by the Executive Director on K-353 – Maintenance and Testing. The four sprinkler heads identified were cleaned and the four tiles that were missing were replaced (see pictures) and now meets the conditions of NFPA 101. The Executive Director and/or designee will continue audits to ensure the sprinkler heads and ceiling tiles remain clean and in place. **4- How the corrective action(s) will be monitored to ensure the deficient practice will no longer recur?** Weekly audits will be conducted for 4 weeks, then bi-weekly for 4 weeks, then monthly audits will be conducted for 2 months and reviewed by QA for a minimum of 6 months.	

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	conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.			

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	6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure the continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 1/25/23 between 10:15 a.m. and 1:10 p.m., the Generator Maintenance Report from 06/17/22 stated the emergency generator recommended replacement at next service of a battery since it was over 4 years old. Furthermore, A service report dated 1/10/23 stated again that the battery recommended replacement. Generator report states the generator is operable at time of maintenance. During interview with the Maintenance Director, they stated they were aware of the report, but did not have documentation for verification of the preventative/routine maintenance at the time of the survey. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0918	**1- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** There were no alleged deficient practices from this alleged deficiency. A generator battery has been ordered. **2- How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** All residents had the potential to be affected by this alleged deficient practice. There were no negative outcomes. **3- What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Director of Plant Operations was educated by the Executive Director on K-918 – Electrical Systems – Essential Electrical System Maintenance and Testing. The battery for the generator is on order. The Executive Director and/or designee will continue audits to ensure the battery is installed and appropriate testing takes place. **4- How the corrective action(s)**	02/14/2023

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			will be monitored to ensure the deficient practice will no longer recur? The Director of Plant Operations has ordered a replacement battery for the generator from Cummins on 2/14/23 (see attached invoice). The expected delivery date within 30 days of order.	
K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed	K 0920	**1- What corrective actions will be accomplished for those**	02/14/2023

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	properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 12 staff and residents in the Legacy unit. Findings include: Based on observation with the Maintenance Director on 01/25/23 between 1:18 p.m. and 3:15 p.m., in the Legacy unit near a water station, a power strip used to power equipment, was not secured, and was dangling from the outlet on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice?** There were no negative outcomes for this alleged deficient practice. The power strip was properly secured. **2- How other residents have the potential to be affected by the same deficient practice will be identified and how will corrective action be taken?** No residents were affected by this alleged deficient practice. **3- What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Director of Plant Operations was educated by the Executive Director on K-920 – Electrical Equipment. The power strip was properly secured and now meets the conditions of NFPA 101. The Executive Director and/or designee will round weekly to ensure that power strips are properly secured and safe for usage. **4- How the corrective action(s) will be monitored to ensure the deficient practice will no longer recur?** Weekly audits will be conducted for 4 weeks, then bi-weekly for 4 weeks, then monthly audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155824	A. BUILDING 01 B. WING	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

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			conducted for 2 months and reviewed by QA for a minimum of 6 months.1-	