STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING -- B. WING	12/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/05/22 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Emergency Preparedness survey, West Bend Nursing and Rehabilitation was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 157 and had a census of 53 at the time of this survey. Quality Review completed on 12/07/22	E 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.**	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Bailey	Executive Director	12/23/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING -- B. WING	12/05/2022

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

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	must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient	E 0004	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient**	12/06/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING -- B. WING	12/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 12/05/22 between 10:33 a.m. and 1:20 p.m., the EPP located at the nurses station had a review date of 2020 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the administrator stated the EPP was updated only on the administrators copy, but no other books were updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure the Emergency binder is reviewed and updated Annually or with any changes. Emergency Binder was updated for AOR unit on 12/6/2022. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. Binder was updated on 12/6/2022 for all units. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 on requirements on updating the EP binder at least annually for every EP binder. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	155355	A. BUILDING -- B. WING	12/05/2022

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water			

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	supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 12/05/22 between 10:33 a.m. and 1:20 p.m., the EPP located at the nurses station had a review date of 2020 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the administrator stated the EPP was updated only on the administrators copy, but no other books were updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0013	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure the Emergency binder is reviewed and updated Annually or with any changes. Emergency Binder was updated for AOR unit on 12/6/2022 to **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. Binder was updated on 12/6/2022 for all units. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 on requirements on updating the EP binder at least annually for every EP binder. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance	12/06/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			Director or designee using the Quality Assessment Tool attached monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at	E 0029	**What corrective action (s) will be accomplished for those residents found to have been**	12/06/2022

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	least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 12/05/22 between 10:33 a.m. and 1:20 p.m., the EPP located at the nurses station had a review date of 2020 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the administrator stated the EPP was updated only on the administrators copy, but no other books were updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure the Emergency binder is reviewed and updated Annually or with any changes. Emergency Binder was updated for AOR unit on 12/6/2022. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. Binder was updated on 12/6/2022 for all units. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 on requirements on updating the EP binder at least annually for every EP binder. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected	

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			upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication			

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	plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and			

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	procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 12/05/22 between 10:33 a.m. and 1:20 p.m., the EPP located at the nurses station had a review date of 2020 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the administrator stated the EPP was updated only on the administrators copy, but no other books were updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure the Emergency binder is reviewed and updated Annually or with any changes. Emergency Binder was updated for AOR unit on 12/6/2022. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. Binder was updated on 12/6/2022 for all units. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 on requirements on updating the EP binder at least annually for every EP binder. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?**	12/06/2022

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			The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
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: 12/05/22 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation 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,	K 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.**	

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WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

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	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) 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 building is fully protected by a 400 kW diesel powered generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 53 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/07/22			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 7 of 7 battery backup emergency lights were tested annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2	K 0291	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure back up emergency	12/06/2022

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	155355	A. BUILDING 01 B. WING	12/05/2022

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

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	hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 12/05/22 between 10:33 a.m. and 1:20 p.m., annual testing for the battery backup emergency lights were past due. Documentation indicated that the lights are tested for 30 seconds a month, but no 90 minute annual. Based on an interview at the time of records review, the Maintenance Director stated the annual 90 minute testing has not been conducted within the past 12 months. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		lighting is tested annually for a duration of 90 minutes. To correct the deficient practice, a 90 min test was completed on 12/6/2022. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all emergency lighting is functioning to regulations during the 90-minute test. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** To ensure the deficient practice does not reoccur, the emergency lighting will be monitored by QA tool. All staff were in-serviced on 12/10/2022 on emergency lighting requirements. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be	

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			monitored by the Maintenance Director or designee using the Quality Assessment Tool attached monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of 16 exit signs were continuously illuminated. This deficient practice could affect all residents and staff using the west end stairwell. Findings include: Based on observations on 12/05/22 during a tour	K 0293	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure that all exit signs placed only where a door leads to a true	12/06/2022

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	of the facility from 1:22 p.m. to 2:56 p.m. with the Maintenance Supervisor, the west side stairwell exit signs were not continuously illuminated. Based on an interview with the Maintenance Supervisor at the time of observation, The Maintenance Director agreed both exit signs were not illuminated. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1.19(b)		exit. The door found to have an exit sign not leading to an exit was taken down and sticker stating that it is not an exit is placed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all exit signage is in the proper placement and only with true exit locations. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 about exit signage placement. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached for 5 different locations weekly for 4 weeks, monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified	

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			issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
K 0920 SS=D 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	K 0920	**What corrective action (s) will**	12/06/2022

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	failed to ensure 1 power strip was not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/05/22 between 1:22 p.m. and 2:56 p.m., a refrigerator (high power draw equipment) was plugged into a powerstrip located in resident room 205. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment and removed the powerstrip from the room. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure that no high-power draw equipment is plugged into a power strip. Resident room 205 who used a personal refrigerator was corrected on 12/5/2022 to be plugged directly into the wall. Family also educated on this requirement. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all resident care vicinities did not have any other high-power draw equipment is plugged into a power strip. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 about the type of power strip or extension cords allowed and what can or can not be plugged into them. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what**	

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			quality assurance program will be put into place? The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached for 5 different locations weekly for 4 weeks, monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a			

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	minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 2 of 10 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 10 residents in one smoke compartment.	K 0923	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure that all oxygen cylinders and containers are secure from tipping over. The 2 type E oxygen cylinders were secured on 12/5/2022. **How will you identify other residents having the potential to be affected by the same**	12/06/2022

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	Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/05/22 between 1:22 p.m. and 2:56 p.m., two 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage/trans-filling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged two 'E' type oxygen cylinders in the oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all oxygen containers were operational and secured. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 about the importance and why we secure all oxygen containers. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached weekly for 4 weeks, monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	

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K 0000 Bldg. 02	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: 12/05/22 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation 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 and 410 IAC 16.2. This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) 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 building is fully protected by a 400 kW diesel powered generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 53 at the time of this survey. All areas where residents have customary access	K 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.**	

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	155355	A. BUILDING 02 B. WING	12/05/2022

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	were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/07/22			
K 0293 SS=F Bldg. 02	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 6 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect all residents, staff, and visitors. Findings include: During a tour of the facility with the Maintenance Director on 12/05/2022 between 1:22 p.m. and 2:56 p.m. a door marked as an emergency exit in the memory care unit led to the courtyard, however, did not lead to a public way. Based on interview at the time of observation, the Maintenance Director stated that the doors are not an emergency exit and agreed that the doors were	K 0293	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure that all exit signs placed only where a door leads to a true exit. The door found to have an exit sign not leading to an exit was taken down and sticker stating that it is not an exit is placed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all exit	12/06/2022

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	marked with EXIT and not NO EXIT, and further agreed that without proper signage occupants could be confused when trying to evacuate. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		signage is in the proper placement and only with true exit locations. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 about exit signage placement. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached for 5 different locations weekly for 4 weeks, monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation			

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	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 10.4.2 requires that devices and appliances shall be located and mounted so that accidental operation or failure is not caused by vibration or jarring. This deficiency could affect all staff in the basement. Findings include: Based on record review with the Maintenance Director on 12/05/22 at 2:22 p.m., the hardwired smoke detector located in the center storage room of the basement was not mounted. At interview upon observation, the Maintenance Director confirmed the issue and would get the contractor out to fix the issue. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	K 0341	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** It's the policy of West Bend Nursing and Rehabilitation to ensure that all smoke detectors are functional and properly mounted. On 12/14/2022 Integrated Electronics of Indiana came and serviced the one smoke detector found to not be mounted due to mounting base being broken. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents could be affected by the deficient practice. An environmental walkthrough was completed to ensure all smoke detectors were mounted and	12/14/2022

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	155355	A. BUILDING 02 B. WING	12/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-19(b)		operational. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff were in-serviced on 12/10/2022 about smoke detectors and how to report if one is found not mounted or not operational. **How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attached for 5 different locations weekly for 4 weeks, monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on the facility QAPI tracking log. The facility QAPI team meets monthly and any QAPI tracking logs are reviewed by the team to ensure ongoing compliance minimum of 6 months and until the facility maintains 95% compliance for 60 days.	
K 0000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 03 B. WING	12/05/2022

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

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Bldg. 03	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: 12/05/22 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation 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 and 410 IAC 16.2. This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) 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 building is fully protected by a 400 kW diesel powered generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 53 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.	K 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 03 B. WING	12/05/2022

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	Quality Review completed on 12/07/22			