PRINTED: 01/06/2023
FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC.	_			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED
		155355	B. WING		12/05/2022
	SUMMARY	D REHABILITATION STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619  ID PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROP		(X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
E 0004 SS=F Bldg	conducted by the In accordance with 42  Survey Date: 12/05/ Facility Number: 10/ Provider Number: 1  AIM Number: 100/ At this Emergency Bend Nursing and Fcompliance with En Requirements for M Participating Provided 483.73. The facility census of 53 at the to Quality Review conductive with the August Participating Provided 403.748(a), 416.5	222 20246 55355 275420  Preparedness survey, West Rehabilitation was found not in mergency Preparedness Idedicare and Medicaid Iders and Suppliers, 42 CFR has a capacity of 157 and had a time of this survey.  Impleted on 12/07/22  4(a), 418.113(a), 5(a), 483.475(a), 483.73(a),	E 0000	Please accept the following the facility's credible allegat of compliance. This plan of correction does not constituan admission of guilt or liab by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.	ion ite ility
J.ug.	485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416 §441.184(a), §460 §483.73(a), §483. §485.68(a), §485. §485.920(a), §486 §494.62(a). The [facility] must Federal, State and	20(a), 486.360(a), (a) Review and Update  5.54(a), §418.113(a), 0.84(a), §482.15(a), 475(a), §484.102(a), 625(a), §485.727(a), 5.360(a), §491.12(a),  comply with all applicable			

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

(X6) DATE

TITLE

Emily Bailey Executive Director 12/23/2022

Any defiency statement 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 disclodays 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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	OF CORRECTION	IDENTIFICATION NUMBER  155355	î ´	JILDING	INSTRUCTION	COMPL 12/05/	ETED
	PROVIDER OR SUPPLIEF	REHABILITATION		4600 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	comprehensive er program that mee section. The emer program must incit the following elem (a) Emergency Pladevelop and main preparedness plarand updated at leamust do all of the * [For hospitals at §485.625(a):] Emor CAH] must comprehensive er program that mee section, utilizing at * [For LTC Facilitie Emergency Plan. develop and main preparedness plarand updated at leamust develop and main preparedness plarand updated at leamust develop and main	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable ind local emergency uirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach.  es at §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually.  ities at §494.62(a):]  The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],					
	failed to review and Preparedness Plan (	view and interview, the facility dupdate the Emergency (EPP) at least annually in CFR 483.73(a). This deficient	E 00	004	What corrective action (s) wi be accomplished for those residents found to have beer affected by the deficient		12/06/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155355	B. WING	<del>-</del>		12/05/2	022
NAME OF P	PROVIDER OR SUPPLIER	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON AVE		
WEST BE	END NURSING AN	D REHABILITATION	{	SOUTH	BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
	practice could affect	et all occupants.			practice?		
	F: 1:				It's the policy of West Bend		
Findings include:  Based on records review with the Maintenance				Nursing and Rehabilitation to			
				ensure the Emergency binder			
					reviewed and updated Annual	-	
		22 between 10:33 a.m. and 1:20			with any changes. Emergency		
	•	ed at the nurses station had a ) on the cover page, no other			Binder was updated for AOR upon 12/6/2022.	arill	
		to show the EPP was			On 12/6/2022.  How will you identify other		
		ted within the last year. Based			residents having the potentia	al	
	_	ring records review, the			to be affected by the same	21	
		I the EPP was updated only on			deficient practice and what		
		copy, but no other books were			corrective action will be take	ın?	
	updated.	opy, out no other books were			All residents could be affected	I	
	upaatea.				the deficient practice. Binder v	-	
	This finding was re	viewed with the Administrator			updated on 12/6/2022 for all u		
	_	rector during the exit			What measures will be put in	I	
	conference.	8			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 of	n	
					updating the EP binder at leas		
					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 w	vill	
					be put into place?		
					The corrective actions will be		
					monitored by the Maintenance		
					Director or designee using the		
					Quality Assessment Tool attac	ched	
					monthly for 6 months and		
					quarterly thereafter for ongoin	g	
					compliance. Any identified		
					issues/trends will be corrected		
					upon discovery and logged on	the	

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	OF CORRECTION	IDENTIFICATION NUMBER  155355	A. BUILDING B. WING	JNSTRUCTION	COMPLETED 12/05/2022
	PROVIDER OR SUPPLIER END NURSING ANI	O REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				facility QAPI tracking log. The facility QAPI team meets mon and any QAPI tracking logs at reviewed by the team to ensu ongoing compliance minimum months and until the facility maintains 95% compliance for days.	thly re re of 6
E 0013 SS=F Bldg	484.102(b), 485.62 485.727(b), 485.92 491.12(b), 494.62( Development of El §403.748(b), §416 §441.184(b), §460 §483.73(b), §485.6 §485.920(b), §486 §494.62(b).  (b) Policies and pr develop and imple preparedness polic on the emergency (a) of this section, paragraph (a)(1) o communication pla section. The polic	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), b)  P Policies and Procedures .54(b), §418.113(b), .84(b), §482.15(b), 475(b), §484.102(b), 525(b), §485.727(b), .360(b), §491.12(b), .360(b), §491.12(b), .360(d), §491.12(d), .360(d), .360(d)			
	and procedures. T develop and imple preparedness poli	at §483.73(b):] Policies he LTC facility must ment emergency cies and procedures, based plan set forth in paragraph			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	i '	UILDING	NSTRUCTION	(X3) DATE COMPI 12/05	LETED
	PROVIDER OR SUPPLIER	D REHABILITATION		4600 W	DDRESS, CITY, STATE, ZIP COE WASHINGTON AVE BEND, IN 46619	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	paragraph (a)(1) c communication pla section. The polic	risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.					
	*Additional Requir ESRD Facilities:	ements for PACE and					
	procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) communication plasection. The polic address managen nonmedical emergimited to: Fire; eq failure; care-related disasters likely to safety of the partic.	PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the en at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or sipants, staff, or the public.					
	and procedures. develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication pla section. The polic be reviewed and u years. These eme not limited to, fire,	ties at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 rgencies include, but are equipment or power ed emergencies, water					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  12/05/2022			
	PROVIDER OR SUPPLIER	D REHABILITATION	460	EET ADDRESS, CITY, STATE, ZIP COD 10 W WASHINGTON AVE UTH BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
PREFIX	supply interruption likely to occur in the area.  Based on record reversible to review and Preparedness Plan's at least annually in a 483.73(a). This definoccupants.  Findings include:  Based on records represent to pirector on 12/05/2 p.m., the EPP locate review date of 2020 date could be found reviewed and updat on an interview duradministrator stated the administrators of updated.  This finding was reversible to occur in the record of the administrators of updated.	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	will 12/06/2022  deen  d to der is nually or ency DR unit  er ential e at aken? cted by er was all units. ut into  n ts on least er.
				duality assurance programe be put into place?  The corrective actions will monitored by the Maintena	be

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	T OF DEFICIENCIES  DF CORRECTION	IDENTIFICATION NUMBER  155355	A. BUILDING B. WING	JNSTRUCTION 	COMPLETED 12/05/2022
	ROVIDER OR SUPPLIER END NURSING ANI	D REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP COD I WASHINGTON AVE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0029 SS=F Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62( Development of Co. §403.748(c), §416 §441.184(c), §460 §483.73(c), §483.4 §485.68(c), §485.6 §485.920(c), §486 §494.62(c).  (c) The [facility] must emergency pre plan that complies local laws and must at least every 2 ye facilities]. Based on record rev to review and update	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan .54(c), §418.113(c), .84(c), §482.15(c), 475(c), §484.102(c), 525(c), §485.727(c), .360(c), §491.12(c), .360(c) The second maintain paredness communication with Federal, State and st be reviewed and updated ars [annually for LTC iew and interview, the failed e the Emergency	E 0029	Director or designee using the Quality Assessment Tool attack monthly for 6 months and quarterly thereafter for ongoing compliance. Any identified issues/trends will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets montand any QAPI tracking logs are reviewed by the team to ensurongoing compliance minimum months and until the facility maintains 95% compliance for days.  What corrective action (s) with the accomplished for those with the facility maintains 95% compliance for days.	thed g l the sthly e re of 6 l 60 l
	Preparedness Plan's	(EPP) Communication Plan at		residents found to have beer	า

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/05/2022
	PROVIDER OR SUPPLIEF	D REHABILITATION	4600 V	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	OPRIATE (X5)  COMPLETION  DATE
	483.73(a). This defoccupants.  Findings include:  Based on records redirector on 12/05/2 p.m., the EPP locate review date of 2020 date could be found reviewed and update on an interview duradministrator stated the administrators of updated.  This finding was redirectors.	cordance with 42 CFR icient practice could affect all eview with the Maintenance 22 between 10:33 a.m. and 1:20 ed at the nurses station had a 0 on the cover page, no other 1 to show the EPP was ed within the last year. Based ing records review, the 1 the EPP was updated only on eopy, but no other books were viewed with the Administrator irector during the exit		affected by the deficient practice?  It's the policy of West Ben Nursing and Rehabilitation ensure the Emergency bir reviewed and updated Ani with any changes. Emerge Binder was updated for Acon 12/6/2022.  How will you identify oth residents having the pote to be affected by the sam deficient practice and who corrective action will be All residents could be affected by the deficient practice. Bindupdated on 12/6/2022 for What measures will be public place or what systemic changes you will make to ensure that the deficient practice does not recur?  All staff were in-serviced of 12/10/2022 on requirement updating the EP binder at annually for every EP binder at a	n to nder is nually or ency OR unit  er ential ne nat taken? cted by der was all units. ut into  on nts on least der.  otice am will be ance g the attached going

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155355 B. WING		ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  12/05/2022			
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
WEST BI	END NURSING ANI	O REHABILITATION		WASHINGTON AVE BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
			-	upon discovery and logged facility QAPI tracking log. T facility QAPI team meets meets and any QAPI tracking logs reviewed by the team to ensongoing compliance minimum months and until the facility maintains 95% compliance days.	he onthly are sure m of 6	
E 0036 SS=F Bldg	484.102(d), 485.6: 485.727(d), 485.9: 491.12(d), 494.62: EP Training and T §403.748(d), §416: §441.184(d), §466: §485.68(d), §485.6: §485.920(d), §486: §494.62(d).  *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625: 485.727, CMHCs: §486.360, and RH Training and testir develop and maining preparedness train that is based on the in paragraph (a) or assessment at par section, policies and	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) resting 5.54(d), §418.113(d), 2.54(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 2.360(d), §491.12(d), 2.360(d), §491.12(d), 3.360(d), 3.360				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	ľ í	UILDING	NSTRUCTION	(X3) DATE COMPI 12/05	LETED
	PROVIDER OR SUPPLIEF	D REHABILITATION		4600 W	NDDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE A) CROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE  COMPLET	
	plan at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The and maintain an etraining and testin the emergency plof this section, ris (a)(1) of this section at paragraph (b) communication pl section. The train	(c) of this section. The g program must be lated at least every 2 years.  s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least					
	annually.  *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing progration emergency plans this section, risk at (a)(1) of this section at paragraph (b) communication placetion. The train must be reviewed 2 years. The ICF/requirements for eat §483.470(i).  *[For ESRD Facilian Training, testing, at §485.470]	S483.475(d):] Training and ID must develop and gency preparedness training am that is based on the set forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least every					
	emergency prepa and patient orient on the emergency (a) of this section,	redness training, testing ation program that is based plan set forth in paragraph risk assessment at of this section, policies and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
		155355	B. W	ING		12/05/	2022	
	PROVIDER OR SUPPLIER	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	and the communic of this section. The orientation program updated at every 2 Based on record reversiled reviewed and Preparedness Plan's Plan at least annual 483.73(a). This definition occupants.  Findings include:  Based on records reduction Director on 12/05/2 p.m., the EPP locate review date of 2020 date could be found reviewed and updat on an interview dure administrator stated the administrators of updated.  This finding was records residually and the second sec	agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and 2 years. View and interview, the facility updated the Emergency (EPP) Training and Testing by in accordance with 42 CFR cient practice could affect all view with the Maintenance 2 between 10:33 a.m. and 1:20 and at the nurses station had a con the cover page, no other to show the EPP was and within the last year. Based ing records review, the the EPP was updated only on opy, but no other books were viewed with the Administrator irector during the exit	EO	036	What corrective action (s) wibe 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 reviewed and updated Annual with any changes. Emergency Binder was updated for AOR on 12/6/2022.  How will you identify other residents having the potentiate obe affected by the same deficient practice and what corrective action will be take All residents could be affected the deficient practice. Binder with updated on 12/6/2022 for all updated on 12/6/2022	n is illy or / unit al d by was units. nto	12/06/2022	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 12/05/2022	
		155355	B. WI	NG		12/05/	2022	
	PROVIDER OR SUPPLIE END NURSING AN	R D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE	
K 0000	REGULATORY	X LSC IDENTIFTING INFORMATION		TAU	The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool attack monthly for 6 months and quarterly thereafter for ongoin compliance. Any identified issues/trends will be corrected upon discovery and logged on facility QAPI tracking log. The facility QAPI team meets mon and any QAPI tracking logs ar reviewed by the team to ensure ongoing compliance minimum months and until the facility maintains 95% compliance for days.	g d the the thly re of 6	DATE	
Bldg. 01	Licensure Survey of Department of Hea 483.90(a).  Survey Date: 12/0  Facility Number: 100  At this Life Safety Nursing and Rehalt compliance with R Medicare/Medicaid Life Safety from Facility North Processing Safety Safety Safety from Facility Department of Heading Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety from Facility Department of Heading Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety from Facility Department of Heading Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life Safety Facility Department of Heading Life Safety Page 12/0  Life	000246 155355	K 00	000	Please accept the following at the facility's credible allegati of compliance. This plan of correction does not constitu an admission of guilt or liabi by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.	ion te lity		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/05/2022		
	PROVIDER OR SUPPLIER	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	,	SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	buildings: Building sprinklered building Building 02, a one sof Type V (000) conbasement and Building The facility has a findetection in the corridors and batter all resident rooms. by a 400 kW diesel facility has a capacifor Medicare and M 53 at the time of thi	dents have customary access Il areas providing facility					
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lightin Emergency Lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on records re failed to ensure 7 of lights were tested at 7.9.3.1.1 (1) require conducted monthly, and a maximum of less than 30 seconds	ng g of at least 1-1/2-hour ed automatically in	K 0291	What corrective action (s) we 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	en		

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FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/05/2022	
			4600 W	WASHINGTON AVE		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
powered and (5) Winspections and test for inspection by th jurisdiction. This d	ritten records of visual s shall be kept by the owner e authority having eficient practice could affect all			duration of 90 minutes. To cor the deficient practice, a 90 mir	rect 1	
Findings include:  Based on records re Director on 12/05/2 p.m., annual testing emergency lights w indicated that the light a month, but no 90 interview at the tim Maintenance Direct	view with the Maintenance 2 between 10:33 a.m. and 1:20 for the battery backup ere past due. Documentation ghts are tested for 30 seconds minute annual. Based on an e of records review, the or stated the annual 90 minute			to be affected by the same deficient practice and what corrective action will be take All residents could be affected the deficient practice. An environmental walkthrough was completed to ensure all emergency lighting is functionic	<b>n?</b> by s	
-				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 emerger lighting will be monitored by Q tool. All staff were in-serviced 12/10/2022 on emergency light requirements.  How will the corrective action(s) be monitored to ensure the deficient practice will not recure, i.e., what	e ncy A on ting	
)	ROVIDER OR SUPPLIER SUMMARY:  (EACH DEFICIEN REGULATORY OR hours if the emerger powered and (5) Wr inspections and test for inspection by th jurisdiction. This d residents in the faci  Findings include:  Based on records re Director on 12/05/2 p.m., annual testing emergency lights wr indicated that the light a month, but no 90 interview at the tim Maintenance Direct testing has not been months.  Findings were discusted and Maintenance D	ROVIDER OR SUPPLIER  IND NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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.	ROVIDER OR SUPPLIER  END NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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.	A. BUILDING B. WING  STREET A 4600 W SOUTH  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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.	ROVIDER OR SUPPLIER  ND NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIE ((EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) 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 state die 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)  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recocur, the emerger lighting will be monitored by Q tool. All staff were in-serviced 12/10/2022 on emergency light requirements.	A BUILDING DENTIFICATION NUMBER 155355  BOVIDER OR SUPPLIER  NO NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING MFORMATION)  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.  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 at exit conference.  Findings were discussed with the Administrator and Maintenance Director at exit conference.  3.1-19(b)  A BUILDING D.  STREET ADDRESS, CITY, STATE, ZIP COD 46000 WASHINGTON AVE SOUTH BEND, IN 46610  BOUTH BEND, IN 46619  ID PROVIDENCE NAME OF CORRECTION (BREICH SOUTH) AND 16000 CARL CORRECTION

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l ′	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG <u>01</u>	COMPLETED	
		155355	B. WING		12/05/2022	
	ROVIDER OR SUPPLIER	D REHABILITATION	460	EET ADDRESS, CITY, STATE, ZIP COD 00 W WASHINGTON AVE OUTH BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN QE CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	E COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAC	G DEFICIENCY)	DATE	
K 0293 SS=E Bldg. 01	accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of 6 Based on observation failed to ensure 2 of continuously illumicould affect all resident stairwell.	ess than 30 occupants exit travel is obvious.) on and interview, the facility	K 0293	monitored by the Maintenand Director or designee using the Quality Assessment Tool attainmentally for 6 months and quarterly thereafter for ongoi compliance. Any identified issues/trends will be corrected upon discovery and logged of facility QAPI tracking log. The facility QAPI tracking logs are viewed by the team to ensongoing compliance minimum months and until the facility maintains 95% compliance for days.  What corrective action (s) we 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 place only where a door leads to a	ne ached ing ed on the ne withly are ure m of 6 or 60 ached ing in the ne will are ure m of 6 or 60 ached in the ne will are ure m of 6 or 60 ached in the ne will ached in the ne will ache ache ache ache ache ache ache ache	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/05/2022 155355 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of the facility from 1:22 p.m. to 2:56 p.m. with the exit. The door found to have an Maintenance Supervisor, the west side stairwell exit sign not leading to an exit exit signs were not continuously illuminated. was taken down and sticker Based on an interview with the Maintenance stating that it is not an exit is Supervisor at the time of observation, The placed. Maintenance Director agreed both exit signs were How will you identify other not illuminated. residents having the potential to be affected by the same Findings were discussed with the Administrator deficient practice and what and Maintenance Director at exit conference. corrective action will be taken? All residents could be affected by 3.1.19(b) 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  12/05/2022		
		133333	B. WII			12/03/	2022
	PROVIDER OR SUPPLIE	R ID REHABILITATION		4600 W	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE I BEND, IN 46619		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipm Extens Electrical Equipm Extension Cords Power strips in a used for compone patient-care-relat (PCREE) assemt assembled by qu the conditions of the patient care v non-PCREE (e.g. except in long-ter do not use PCRE meet UL 1363A of for non-PCREE ir (outside of vicinity non-patient care other UL standard used with genera cords are not use wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 9 (NFPA 70), 590.3	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment bles that have been alified personnel and meet 10.2.3.6. Power strips in icinity may not be used for , personal electronics), m care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms by) meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension d as a substitute for fixed ire. Extension cords used emoved immediately upon purpose for which it was ets the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 e(D) (NFPA 70), TIA 12-5 on and interview, the facility	K 09	TAG	issues/trends will be corrected upon discovery and logged or facility QAPI tracking log. The facility QAPI team meets mon and any QAPI tracking logs at reviewed by the team to ensu ongoing compliance minimum months and until the facility maintains 95% compliance for days.  What corrective action (s) with the facility of the facility maintains 95% compliance for days.	n the e e hthly re re n of 6 r 60	12/06/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>		COMPLETED	
		155355	B. W	ING		12/05/2022	
			_	STREET	ADDRESS, CITY, STATE, ZIP COD	<u>.                                    </u>	
NAME OF I	PROVIDER OR SUPPLIEF	3			/ WASHINGTON AVE		
WEST B	FND NURSING AN	D REHABILITATION			H BEND, IN 46619		
		-			1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	ower strip was not used as a			be accomplished for those		
		wiring to provide power			residents found to have been	n	
	equipment with a h	-			affected by the deficient		
		0.8 state unless specifically			practice?		
	_	flexible cords and cables shall			It's the policy of West Bend		
		as a substitute for fixed wiring.			Nursing and Rehabilitation to		
	_	cice could affect up to 2			ensure that no high-power dra		
	residents.				equipment is plugged into a po		
	F' 1' ' 1 1				strip. Resident room 205 who		
	Findings include:				used a personal refrigerator w	as	
	D 1 1	1			corrected on 12/5/2022 to be		
		ons during a tour of the facility ace Director on 12/05/22			plugged directly into the wall.		
					Family also educated on this		
	_	and 2:56 p.m., a refrigerator			requirement.		
		equipment) was plugged into a			How will you identify other	-1	
		in resident room 205. Based on			residents having the potentia	aı	
		e of observation, the tor acknowledged power strips			to be affected by the same		
		ver to high power draw			deficient practice and what	2	
		oved the powerstrip from the			corrective action will be take All residents could be affected		
	room.	oved the powership from the			the deficient practice. An	1 Dy	
	100111.				environmental walkthrough wa	ae .	
	Findings were disci	ussed with the Maintenance			completed to ensure all reside		
	_	nistrator at exit conference.			care vicinities did not have an		
	Birector and riamin	instruct at exit conference.			other high-power draw equipn	-	
	3.1-19(b)				is plugged into a power strip.		
	J.1 15(0)				What measures will be put in	nto	
					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	s	
					allowed and what can or can r		
					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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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE S COMPL 12/05/	ETED
	PROVIDER OR SUPPLIER	D REHABILITATION	4600 V	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or ecceptate of the storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 cceptations enclosure or within space of non- or lice construction, with that can be secure stored with flammate from combustibles sprinklered) or encompared.	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 ubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and Oxidizing gases are not ables, and are separated aby 20 feet (5 feet if closed in a cabinet of construction having a		quality assurance progrebe put into place? The corrective actions will monitored by the Mainten Director or designee usin Quality Assessment Tool for 5 different locations will weeks, monthly for 6 mand quarterly thereafter for compliance. Any identified issues/trends will be correspond discovery and logger facility QAPI tracking logg	Il be nance g the attached neekly for onths or ongoing d nected need on the The monthly gs are num of 6 ity	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u> 01                                   </u>	COMPLETED	
		155355	B. WING		12/05/2022	
	PROVIDER OR SUPPLIER END NURSING AN	R REHABILITATION	460	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		E COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Less than or equal In a single smoke cylinders available patient care areas of less than or equivequired to be stored Cylinders must be as specified in 11. A precautionary sion each door or groom, where the saminimum "CAU" STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with intee threshold pressure established. Empayoid confusion. Care protected from	ign readable from 5 feet is ate of a cylinder storage sign includes the wording as FION: OXIDIZING GAS(ES) I NO SMOKING." If you can be seen to				
	failed to ensure 2 of gases such as oxyge falling. NFPA 99, 1 2012 Edition, Section nonflammable gase (300 cubic feet) but (3000 cubic feet) sh through 11.3.2.3. Neylinder or contained 11.6.2.3. Section 1 cylinders shall be p in a proper cylinder	on and interview, the facility f 10 cylinders of nonflammable en were properly secured from Health Care Facilities Code, on 11.3.2 states storage for s greater than 8.5 cubic meters eless than 85 cubic meters hall comply with 11.3.2.1 NFPA 99, Section 11.3.2.6 states er restraints shall comply with 1.6.2.3(11) states freestanding roperly chained or supported e stand or cart. This deficient et 10 residents in one smoke	K 0923	What corrective action (s) to be accomplished for those residents found to have be affected by the deficient practice?  It's the policy of West Bend Nursing and Rehabilitation to ensure that all oxygen cylind and containers are secure fre tipping over. The 2 type E oxylinders were secured on 12/5/2022.  How will you identify other residents having the potent to be affected by the same	en O Jers Om Kygen	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/05/2022 155355 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE deficient practice and what Findings include: corrective action will be taken? All residents could be affected by Based on observations during a tour of the facility the deficient practice. An with the Maintenance Director on 12/05/22 environmental walkthrough was between 1:22 p.m. and 2:56 p.m., two 'E' type completed to ensure all oxygen oxygen cylinders were standing upright on the containers were operational and floor of the oxygen storage/trans-filling room and secured. were not properly chained or supported in a What measures will be put into proper cylinder stand or cart. Based on interview place or what systemic at the time of observation, the Maintenance changes you will make to Director acknowledged two 'E' type oxygen ensure that the deficient cylinders in the oxygen storage/trans-filling room practice does not recur? were not properly chained or supported in a All staff were in-serviced on proper cylinder stand or cart. 12/10/2022 about the importance and why we secure all oxygen The finding was reviewed with the Administrator containers. and the Maintenance Director during the exit How will the corrective conference. action(s) be monitored to ensure the deficient practice 3.1-19(b) 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ì í	JLTIPLE CO	onstruction 01	(X3) DATE SURVEY COMPLETED		
		155355	B. WI	NG	_	12/05/2022	
	PROVIDER OR SUPPLIE	R ID REHABILITATION		4600 W	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE I BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLET DATE	
K 0000							
Bldg. 02	Licensure Survey of Department of Hea 483.90(a).  Survey Date: 12/0  Facility Number: 12/0  Facility Number: 10/0  At this Life Safety Nursing and Rehabt compliance with R Medicare/Medicaid Life Safety from F National Fire Prote Life Safety Code (Health Care Occup This facility consist buildings: Building sprinklered building Building 02, a one of Type V (000) con basement and Build sprinklered building The facility has a fact detection in the concorridors and batter all resident rooms. By a 400 kW dieself facility has a capact for Medicare and	Code survey, West Bend bilitation was found not in equirements for Participation in 1, 42 CFR Subpart 483.90(a), ire and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing bancies and 410 IAC 16.2.  Its of three connected (301, a two story, fully g of Type II (222) construction; story, fully sprinklered building bantruction with a partial ding 03, a one story, fully g of Type V (111) construction. Ire alarm system with smoke rridors, in spaces open to the rry operated smoke detectors in The building is fully protected I powered generator. The ity of 157 beds dually certified Medicaid and had a census of	K 00	000	Please accept the following at the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.	on te lity	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155355	B. W	NG		12/05/2022	
	ROVIDER OR SUPPLIER	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ll areas providing facility					
	services were sprink	dered.					
	Quality Review con	npleted on 12/07/22					
K 0293	NFPA 101						
SS=F	Exit Signage						
Bldg. 02	Exit Signage						
	2012 EXISTING						
	Exit and directiona	al signs are displayed in					
	accordance with 7	.10 with continuous					
	illumination also se	erved by the emergency					
	lighting system.						
	19.2.10.1						
	(Indicate N/A in or						
	•	ess than 30 occupants					
		exit travel is obvious.)					
		on and interview, the facility	K 0	293	What corrective action (s) will	ıI	12/06/2022
		6 doors to the outside of the			be accomplished for those		
	-	staken as a facility exit. LSC			residents found to have been	í	
	-	door, passage, or stairway it nor a way of exit access and			affected by the deficient		
		ranged so that it is likely to be			practice? It's the policy of West Bend		
		shall be identified by a sign			Nursing and Rehabilitation to		
		s: NO EXIT. The NO EXIT			ensure that all exit signs place	d	
		word NO in letters 2 inches			only where a door leads to a tr		
	-	width of 3/8ths inch, and the			exit. The door found to have a		
	-	he word NO, unless such sign			exit sign not leading to an exit	•	
		ing sign. This deficient			was taken down and sticker		
	practice could affect	t all residents, staff, and			stating that it is not an exit is		
	visitors.				placed.		
	Findings include:				How will you identify other		
	•	facility with the Maintenance			residents having the potentia	ıl	
		022 between 1:22 p.m. and 2:56			to be affected by the same		
	•	as an emergency exit in the			deficient practice and what		
	-	ed to the courtyard, however,			corrective action will be take		
	•	blic way. Based on interview			All residents could be affected	by	
		vation, the Maintenance			the deficient practice. An		
	Director stated that				environmental walkthrough wa	S	
	emergency exit and	agreed that the doors were			completed to ensure all exit		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  02	(X3) DATE SURVEY COMPLETED 12/05/2022
	PROVIDER OR SUPPLIEF	D REHABILITATION	4600 V	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
	agreed that without could be confused v	and not NO EXIT, and further proper signage occupants when trying to evacuate. viewed with the Administrator		signage is in the proper p and only with true exit loc	
	I -	irector at the exit conference.		What measures will be place or what systemic changes you will make the ensure that the deficient practice does not recur? All staff were in-serviced 12/10/2022 about exit sign placement.  How will the corrective action(s) be monitored the ensure the deficient practice will not recure, i.e., what quality assurance programs be put into place?  The corrective actions will monitored by the Maintent Director or designee usin Quality Assessment Tool for 5 different locations will weeks, monthly for 6 m and quarterly thereafter for compliance. Any identified issues/trends will be corrective upon discovery and logger facility QAPI tracking logure facility QAPI tracking logure in the program of the team to expense of the program of the team to expense of the place of the	to t con inage  co ctice t am will  ll be nance g the attached eekly for onths or ongoing d ected ed on the The monthly gs are ensure mum of 6 ity
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm Systen Fire Alarm Systen				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 12/05/2022 155355 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0341 What corrective action (s) will 12/14/2022 failed to ensure 1 of 1 fire alarm systems was be accomplished for those maintained in accordance with LSC 9.6.1.3. LSC residents found to have been 9.6.1.3 requires a fire alarm system to be installed, affected by the deficient tested, and maintained in accordance with NFPA practice? 70, National Electrical Code and NFPA 72, It's the policy of West Bend National Fire Alarm Code. NFPA 72, Section Nursing and Rehabilitation to 10.4.2 requires that devices and appliances shall ensure that all smoke detectors be located and mounted so that accidental are functional and properly operation or failure is not caused by vibration or mounted. On 12/14/2022 jarring. This deficiency could affect all staff in the Integrated Electronics of Indiana basement. came and serviced the one smoke detector found to not be mounted Findings include: due to mounting base being broken. Based on record review with the Maintenance How will you identify other Director on 12/05/22 at 2:22 p.m., the hardwired residents having the potential smoke detector located in the center storage room to be affected by the same of the basement was not mounted. At interview deficient practice and what upon observation, the Maintenance Director corrective action will be taken? confirmed the issue and would get the contractor All residents could be affected by out to fix the issue. the deficient practice. An environmental walkthrough was This finding was reviewed with the Administrator completed to ensure all smoke

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and Maintenance Director at the exit conference.

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detectors were mounted and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 02 COMPLETED  B. WING 12/05/2022			ETED		
NAME OF P	ROVIDER OR SUPPLIER	 \			ADDRESS, CITY, STATE, ZIP COD		
WEST BE	END NURSING AN	D REHABILITATION			WASHINGTON AVE		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	2.4.40(1)				operational.		
	3.1-19(b)				What measures will be put in 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 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 who be put into place? The corrective actions will be monitored by the Maintenance Director or designee using the Quality Assessment Tool atta for 5 different locations week! 4 weeks, monthly for 6 month and quarterly thereafter for or compliance. Any identified issues/trends will be corrected upon discovery and logged or facility QAPI tracking log. The facility QAPI tracking logs a reviewed by the team to ensu ongoing compliance minimum months and until the facility maintains 95% compliance for days.	one  will  e e e ched y for s e e e e e e e e e e e e e e e e e e	
K 0000							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	COMPLETED	
		155355	B. W	NG		12/05/2022
				CTREET	ADDRESS SITE OF THE SOL	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
WEST DE	THE NUMBER OF ANI				/ WASHINGTON AVE	
MESIBE	END NURSING ANI	D REHABILITATION		50016	HBEND, IN 46619	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				DATE
Bldg. 03						
	A Life Safety Code	Recertification and State	K 0	000	Please accept the following a	s
	Licensure Survey w	as conducted by the Indiana			the facility's credible allegati	on
	Department of Heal	th in accordance with 42 CFR			of compliance. This plan of	
	483.90(a).				correction does not constitut	e
					an admission of guilt or liabil	ity
	Survey Date: 12/05	5/22			by the facility and is submitte	ed
					only in response to the	
	Facility Number: 0				regulatory requirement. We	
	Provider Number: 1	55355			respectfully request	
	AIM Number: 1002	275420			consideration for paper	
					compliance.	
	-	Code survey, West Bend				
	-	litation was found not in				
	-	equirements for Participation in				
		, 42 CFR Subpart 483.90(a),				
	-	re and the 2012 edition of the				
		ction Association (NFPA) 101,				
	•	SC), Chapter 19, Existing				
	Health Care Occupa	ancies and 410 IAC 16.2.				
	This facility consists					
		01, a two story, fully				
		g of Type II (222) construction;				
	•	story, fully sprinklered building				
		nstruction with a partial				
		ing 03, a one story, fully				
		g of Type V (111) construction.				
	•	re alarm system with smoke				
		ridors, in spaces open to the				
		y operated smoke detectors in				
		The building is fully protected				
	-	powered generator. The ty of 157 beds dually certified				
		ledicaid and had a census of				
	53 at the time of this					
	JJ at the time of this	s survey.				
	All grage where resi	dents have customary access				
		ll areas providing facility				
	services were sprink					
	services were sprink	AICIOU.				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/05/2022	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619					
(X4) ID PREFIX		UMMARY STATEMENT OF DEFICIENCIE  DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	DATE	
	Quality Review con	npleted on 12/07/22						

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