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 _____	C 10/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00443715 and IN00443738. Complaint IN00443715- No deficiencies related to the allegations are cited. Complaint IN00443738- No deficiencies related to the allegations are cited. Survey dates: October 8, 2024 Facility number: 000246 Provider number: 155355 AIM number: 100275420 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 1 Medicaid: 38 Other: 15 Total: 54 West Bend Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00443715 and IN00443738. Quality Review completed on 10/10/2024	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE