| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831 |  | A. BU   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   |   | (X3) DATE SURVEY COMPLETED 08/03/2022 |                            |  |
|--|--|---|--|---|---|---------------------------------------|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  BRIARCLIFF HEALTH & REHABILITATION CENTER                                  |  |   |  | STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619 |   |                                       |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   |   |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |                                       | (X5)<br>COMPLETION<br>DATE |  |
| K 0000<br>Bldg. 01   | T18/19 beds in room 512, 514, 301 and 30 Indiana Department 42 CFR 483 Subpar Comprehensive bed T18/19 beds to 131 Survey Date: 08/03 Facility Number: 0 Provider Number: AIM Number: 2012 At this Preoccupance and Rehabilitation Compliance with Re Medicare/Medicaid. Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of the Survey Brinklere system with smoke areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where resident and the survey and the survey areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where residence areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where residence areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where residence for the survey and the survey areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where residence for the survey and the survey areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where residence for the survey and the survey areas open to the codetectors in all residence facility has a capacing 85 at the time of this All areas where residence for the survey and the survey areas open to the codetectors in all residence for the survey and the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors in all residence for the survey areas open to the codetectors | count change from 111 T18/19 beds.  //22  13420 155831 293620  Ey Survey, Briarcliff Health Center was found not in quirements for Participation in , 42 CFR Subpart 483.90(a), Ee, and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  Eity with a basement was Type II (000) construction and d. The facility has a fire alarm detection in the corridors, all rridor and hard-wired smoke lent sleeping rooms. The ty of 111 and had a census of s survey.  dents have customary access d all areas providing facility | K 0  | 000   | A contractor has been hired to complete requirements for the rooms found to be out of compliance. (rooms 301, 302, 400, 401, 402, 403, 404, 405, 410, 411, 500.)  Corridor door 409 was repaire The door closes properly as required.  A spring hinge was installed of the soiled utility door on 300 head The door automatically closes completely as required.  POC date 9/3/22 | ,<br>406,<br>d.<br>n<br>all.          |                            |  |

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

TITLE

(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4EQW21 Facility ID: 013420 If continuation sheet Page 1 of 6

| STATEMENT OF DEFICIENCIES                 |   | X1) PROVIDER/SUPPLIER/CLIA        |          | (X2) MULTIPLE CONSTRUCTION       |                      |  | (X3) DATE SURVEY |            |
|---|---|-----------------------------------|----------|----------------------------------|----------------------|--|------------------|------------|
| AND PLAN OF CORRECTION                    |   | IDENTIFICATION NUMBER             | A. BU    | A. BUILDING <u>01</u>            |                      |  | COMPLETED        |            |
|   |   | 155831                            | B. W     | ING                              | 08/03/               | 08/03/2022   |                  |            |
|   |   |                                   | STREET A | ADDRESS,                         | CITY, STATE, ZIP COD |  |                  |            |
| NAME OF PROVIDER OR SUPPLIER              |   |                                   |          |                                  |                      | N AVENUE   |                  |            |
| BRIARCLIFF HEALTH & REHABILITATION CENTER |   |                                   |          | SOUTH BEND, IN 46619             |                      |  |                  |            |
| (X4) ID                                   | SUMMARY STATEMENT OF DEFICIENCIE  |                                   |          | ID PROVIDER'S PLAN OF CORRECTION |                      |  | (X5)             |            |
| PREFIX                                    | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |                                   |          | PREFIX                           | (EACH<br>CROSS-I     | I CORRECTIVE ACTION SHOULD BE<br>REFERENCED TO THE APPROPRIA | TE.              | COMPLETION |
| TAG                                       |   | R LSC IDENTIFYING INFORMATION     | _        | TAG                              |                      | DEFICIENCY)  |                  | DATE       |
|   | Quality Review con  | mpleted on 08/04/22               |          |                                  |                      |  |                  |            |
| K 0321                                    | NEDA 404  |                                   |          |                                  |                      |  |                  |            |
| SS=E                                      | NFPA 101<br>Hazardous Areas   | Engloque                          |          |                                  |                      |  |                  |            |
| Bldg. 01                                  |   |                                   |          |                                  |                      |  |                  |            |
| Blug. 01                                  | Hazardous Areas   | are protected by a fire           |          |                                  |                      |  |                  |            |
|   |   | our fire resistance rating        |          |                                  |                      |  |                  |            |
|   | _   | rated doors) or an                |          |                                  |                      |  |                  |            |
|   | •   | nguishing system in               |          |                                  |                      |  |                  |            |
|   |   | 3.7.1 or 19.3.5.9. When the       |          |                                  |                      |  |                  |            |
|   |   | tic fire extinguishing system     |          |                                  |                      |  |                  |            |
|   | • •   | e areas shall be separated        |          |                                  |                      |  |                  |            |
|   | -   | by smoke resisting                |          |                                  |                      |  |                  |            |
|   | •   | ors in accordance with 8.4.       |          |                                  |                      |  |                  |            |
|   | Doors shall be sel  |                                   |          |                                  |                      |  |                  |            |
|   |   | and permitted to have             |          |                                  |                      |  |                  |            |
|   | _   | applied protective plates that    |          |                                  |                      |  |                  |            |
|   |   | inches from the bottom of         |          |                                  |                      |  |                  |            |
|   | the door.   |                                   |          |                                  |                      |  |                  |            |
|   | Describe the floor  | and zone locations of             |          |                                  |                      |  |                  |            |
|   |   | that are deficient in             |          |                                  |                      |  |                  |            |
|   | REMARKS.  |                                   |          |                                  |                      |  |                  |            |
|   | 19.3.2.1, 19.3.5.9  |                                   |          |                                  |                      |  |                  |            |
|   |   |                                   |          |                                  |                      |  |                  |            |
|   | Area  | Automatic Sprinkler               |          |                                  |                      |  |                  |            |
|   | •   | N/A                               |          |                                  |                      |  |                  |            |
|   |   | -Fired Heater Rooms               |          |                                  |                      |  |                  |            |
|   | b. Laundries (large   | er than 100 square feet)          |          |                                  |                      |  |                  |            |
|   |   | nance, and Paint Shops            |          |                                  |                      |  |                  |            |
|   |   | ooms (exceeding 64                |          |                                  |                      |  |                  |            |
|   | gallons)  |                                   |          |                                  |                      |  |                  |            |
|   | e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe |                                   |          |                                  |                      |  |                  |            |
|   |   |                                   |          |                                  |                      |  |                  |            |
|   |   |                                   |          |                                  |                      |  |                  |            |
|   |   |                                   |          |                                  |                      |  |                  |            |
|   |   |                                   |          |                                  |                      |  |                  |            |
|   | Hazard - see K32  |                                   |          | 201                              | 1400 :               | 4.0  |                  | 00/02/2022 |
|   |   | on and interview, the facility    | K 0      | 321                              | K321                 | 1. Spring hinge was  |                  | 09/03/2022 |
|   |   | f 1 500-hall soiled utility rooms |          |                                  |                      | d on soiled utility room                                     |                  |            |
|   | were protected as a hazardous area with a   |                                   |          |                                  | door or              | n 300 hall. The door   |                  |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EQW21 Facility ID: 013420

If continuation sheet Page 2 of 6

| STATEMENT OF DEFICIENCIES |   | X1) PROVIDER/SUPPLIER/CLIA        | (X2) M             | IULTIPLE CO                      | ONSTRUCTION   | (X3) DATE SURVEY |            |  |  |
|---------------------------|---|-----------------------------------|--------------------|----------------------------------|---|------------------|------------|--|--|
| AND PLAN OF CORRECTION    |   | IDENTIFICATION NUMBER             | A. B               | UILDING                          | 01  | COMPLETED        |            |  |  |
|                           |   | 155831                            | B. WING 08/03/2022 |                                  |   |                  |            |  |  |
| V. V. C. O. D. D.         |   |                                   |                    | STREET A                         | ADDRESS, CITY, STATE, ZIP COD                                       |                  |            |  |  |
| NAME OF P.                | ROVIDER OR SUPPLIER                                   |                                   |                    |                                  | /ESTERN AVENUE  |                  |            |  |  |
| BRIARCL                   | IFF HEALTH & RE                                       | HABILITATION CENTER               |                    | SOUTH BEND, IN 46619             |   |                  |            |  |  |
| (X4) ID                   | SUMMARY STATEMENT OF DEFICIENCIE                      |                                   |                    | ID PROVIDER'S PLAN OF CORRECTION |   |                  | (X5)       |  |  |
| PREFIX                    | (EACH DEFICIENCY MUST BE PRECEDED BY FULL             |                                   |                    | PREFIX                           | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE.             | COMPLETION |  |  |
| TAG                       |   | LSC IDENTIFYING INFORMATION       | _                  | TAG                              | DEFICIENCY)   | DATE             |            |  |  |
|                           | self-closing door that would automatically latch      |                                   |                    |                                  | automatically closes complete                                       | ely              |            |  |  |
|                           | into the frame. This deficient practice could 12      |                                   |                    | as required.                     |   |                  |            |  |  |
|                           | residents in the 500-hall.                            |                                   |                    |                                  |   |                  |            |  |  |
|                           |   |                                   |                    |                                  | 2. Residents on the 3   |                  |            |  |  |
|                           | Findings include:                                     |                                   |                    |                                  | hall had the potential of being                                     |                  |            |  |  |
|                           |   |                                   |                    |                                  | affected by this deficient pract                                    |                  |            |  |  |
|                           |   | ons with the Maintenance          |                    |                                  |   |                  |            |  |  |
|                           |   | ator, and Admissions Admin        |                    |                                  | 3. All hazardous door   | rs in            |            |  |  |
|                           |   | 3 a.m., the soiled utility room   |                    |                                  | the facility will be check for                                      |                  |            |  |  |
|                           | •   | arrels of trash and soiled linen) |                    |                                  | compliance.   |                  |            |  |  |
|                           | by room 500 was left open. Upon inspection, the       |                                   |                    |                                  |   |                  |            |  |  |
|                           | self-closing device was removed from the door         |                                   |                    |                                  | 4. The maintenance  |                  |            |  |  |
|                           | and laying on a shelf. Based on interview at the      |                                   |                    |                                  | director will identify the location                                 | ns               |            |  |  |
|                           | time of observation, the Maintenance Director         |                                   |                    |                                  | of all hazardous doors and  |                  |            |  |  |
|                           | agreed the soiled utility room door was missing       |                                   |                    |                                  | schedule them to be checked   |                  |            |  |  |
|                           | the closing device and stated it will be reinstalled. |                                   |                    |                                  | monthly basis for compliance.                                       |                  |            |  |  |
|                           |   |                                   |                    |                                  | The maintenance director will                                       |                  |            |  |  |
|                           | This finding was reviewed with the Maintenance        |                                   |                    |                                  | report on this item to QAPI for                                     | the              |            |  |  |
|                           | Director, Administrator, and Admissions Admin         |                                   |                    |                                  | next six months.  |                  |            |  |  |
|                           | during the exit conference.                           |                                   |                    |                                  |   |                  |            |  |  |
|                           | 3.1-19(a)   |                                   |                    |                                  |   |                  |            |  |  |
| K 0363                    | NFPA 101  |                                   |                    |                                  |   |                  |            |  |  |
| SS=E                      | Corridor - Doors                                      |                                   |                    |                                  |   |                  |            |  |  |
| Bldg. 01                  | Corridor - Doors                                      |                                   |                    |                                  |   |                  |            |  |  |
|                           | Doors protecting of                                   | corridor openings in other        |                    |                                  |   |                  |            |  |  |
|                           | than required enclosures of vertical openings,        |                                   |                    |                                  |   |                  |            |  |  |
|                           | exits, or hazardous areas resist the passage          |                                   |                    |                                  |   |                  |            |  |  |
|                           | of smoke and are made of 1 3/4 inch                   |                                   |                    |                                  |   |                  |            |  |  |
|                           | solid-bonded core wood or other material              |                                   |                    |                                  |   |                  |            |  |  |
|                           |   | g fire for at least 20            |                    |                                  |   |                  |            |  |  |
|                           | •   | fully sprinklered smoke           |                    |                                  |   |                  |            |  |  |
|                           |   | only required to resist the       |                    |                                  |   |                  |            |  |  |
|                           | passage of smoke. Corridor doors and doors            |                                   |                    |                                  |   |                  |            |  |  |
|                           | to rooms containing                                   |                                   |                    |                                  |   |                  |            |  |  |
|                           |   | rials have positive latching      |                    |                                  |   |                  |            |  |  |
|                           |   | atches are prohibited by          |                    |                                  |   |                  |            |  |  |
|                           |   | hese requirements do not          |                    |                                  |   |                  |            |  |  |
|                           | -   | spaces that do not contain        |                    |                                  |   |                  |            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EQW21 Facility ID: 013420

If continuation sheet Page 3 of 6

| STATEMENT OF DEFICIENCIES                           |   | X1) PROVIDER/SUPPLIER/CLIA                             | ľ    | ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                                     |   |         |            |  |  |
|---|---|--|------|--|---|---------|------------|--|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831 |   | IDENTIFICATION NUMBER                                  |      | A. BUILDING <u>01</u> COMPLETER  B. WING 08/03/202:                          |   |         |            |  |  |
|   |   | 133031   | D. W | _  |   | 00/03/  | 72022      |  |  |
| NAME OF PROVIDER OR SUPPLIER                        |   |  |      |  | ADDRESS, CITY, STATE, ZIP COD                                     |         |            |  |  |
| BRIARCLIFF HEALTH & REHABILITATION CENTER           |   |  |      | 5024 WESTERN AVENUE<br>SOUTH BEND, IN 46619                                  |   |         |            |  |  |
| (X4) ID   | SUMMARY STATEMENT OF DEFICIENCIE  |  |      | ID PROVIDER'S PLAN OF CORRECTION   |   |         | (X5)       |  |  |
| PREFIX  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |      | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |   |         | COMPLETION |  |  |
| TAG   | REGULATORY OR LSC IDENTIFYING INFORMATION   |  |      | TAG  | DEFICIENCY)   | DATE    |            |  |  |
|   | flammable or combustible material.  |  |      |  |   |         |            |  |  |
|   |   | en bottom of door and floor                            |      |  |   |         |            |  |  |
|   | _   | ceeding 1 inch. Powered                                |      |  |   |         |            |  |  |
|   |   | with 7.2.1.9 are permissible device capable of keeping |      |  |   |         |            |  |  |
|   |   | hen a force of 5 lbf is                                |      |  |   |         |            |  |  |
|   |   | no impediment to the                                   |      |  |   |         |            |  |  |
|   |   | rs. Hold open devices that                             |      |  |   |         |            |  |  |
|   | _   | door is pushed or pulled are                           |      |  |   |         |            |  |  |
|   |   | ed protective plates of                                |      |  |   |         |            |  |  |
|   | unlimited height a  | re permitted. Dutch doors                              |      |  |   |         |            |  |  |
|   | meeting 19.3.6.3.6 are permitted. Door  |  |      |  |   |         |            |  |  |
|   | frames shall be labeled and made of steel or  |  |      |  |   |         |            |  |  |
|   |   | compliance with 8.3,                                   |      |  |   |         |            |  |  |
|   | unless the smoke  |  |      |  |   |         |            |  |  |
|   | · ·   | I fire window assemblies are                           |      |  |   |         |            |  |  |
|   | •   | n sprinklered compartments ictions in area or fire     |      |  |   |         |            |  |  |
|   |   | s or frames in window                                  |      |  |   |         |            |  |  |
|   | assemblies.   | o or married in window                                 |      |  |   |         |            |  |  |
|   | 19.3.6.3. 42 CFR  | Parts 403, 418, 460, 482,                              |      |  |   |         |            |  |  |
|   | 483, and 485  | ,,,  |      |  |   |         |            |  |  |
|   | Show in REMARK  | KS details of doors such as                            |      |  |   |         |            |  |  |
|   | fire protection rati  | ngs, automatics closing                                |      |  |   |         |            |  |  |
|   | devices, etc.   |  |      |  |   |         |            |  |  |
|   |   | on and interview, the facility                         | K 0  | 363  | K363 1. The corridor for room                                     |         | 09/03/2022 |  |  |
|   |   | f 20 resident room corridor                            |      |  | was repaired. The door close                                      | s       |            |  |  |
|   | _   | with a means suitable for                              |      |  | properly as required.   |         |            |  |  |
|   | keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 |  |      |  | 2 This deficient prestice -#-                                     | atad    |            |  |  |
|   |   |  |      |  | 2. This deficient practice affect two residents living in room 40 |         |            |  |  |
|   | residents in room 4   | -  |      |  | two residents living in room 40                                   | ,       |            |  |  |
|   | Findings include:   |  |      |  | All resident room corridor d                                      | loors   |            |  |  |
|   |   |  |      |  | will be checked monthly for pro-                                  |         |            |  |  |
|   |   |  |      |  | closure. This activity will be                                    | • • • • |            |  |  |
|   |   | ons with the Maintenance                               |      |  | documented by the maintenar                                       | ice     |            |  |  |
|   | Director, Administrator, and Admissions Admin   |  |      |  | director. Room corridor doors                                     |         |            |  |  |
|   |   | 3 a.m., the corridor door to                           |      |  | found not closing properly will                                   | be      |            |  |  |
|   | resident room 409 did not latch into the frame  |  |      |  | repaired / adjusted to close                                      |         |            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4EQW21 Facility ID: 013420

If continuation sheet Page 4 of 6

PRINTED: 08/26/2022

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES                          |  |   |        |                           |  |  | FORM APPROVED<br>OMB NO. 0938-039 |  |
|---|--|---|--------|---------------------------|--|--|-----------------------------------|--|
| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155831 |  | ` ´   | ILDING | onstruction<br><u>0</u> 1 | (X3) DATE SURVEY  COMPLETED  08/03/2022  |  |                                   |  |
| NAME OF 1   | PROVIDER OR SUPPLIE  | R   |        |                           | ADDRESS, CITY, STATE, ZIP COD<br>VESTERN AVENUE  |  |                                   |  |
| BRIARC  | LIFF HEALTH & RE   | EHABILITATION CENTER  |        | SOUTI                     | H BEND, IN 46619   |  |                                   |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENT REGULATORY O   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION On interview at the time of   | 1      | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPROFICIENCY)  properly.   | BE   | (X5)<br>COMPLETION<br>DATE        |  |
|   | observation, the Ad<br>Admin stated the c<br>into the door frame<br>This finding was re<br>Director, Administ  | observation, the Administrator, and Admissions Admin stated the corridor door would not latch into the door frame and needs to be repaired.  This finding was reviewed with the Maintenance Director, Administrator, and Admissions Admin during the exit conference.   |        |                           | 4. The Maintenance Director responsible to check rooms monthly basis and documer check when completed.  Maintenance Director will rethis item to QAPI for the neamonths.   | on a<br>nt this<br>eport on  |                                   |  |
| K 9999  |  |   |        |                           |  |  |                                   |  |
| Bldg. 01  | 3.1-19(a) The facil constructed, equipp the health and safe the public. 3.1-19(k)(7) Excep must have ceiling s screens of flamepro which extend arour visual privacy, in c and curtains. 3.1-19(u)(1) The modern to receive resident system from the result. This State Rule has 1) Based on observing failed to provide puresident sleeping resident sleeping res | ity must be designed, bed, and maintained to protect by of residents, personnel, and at in private rooms, each bed suspended cubicle curtains or pof or flame-retardant material, and the bed to provide total combination with adjacent walls surses' station must be equipped calls through a communication sident rooms.  It is not been met as evidenced by:  It is not been met as evidenced by: | K 99   | 999                       | K9999 1. A contractor had hired to complete the work frooms (rooms 301, 302, 400, 402, 403, 404, 405, 406, 41 and 500) The scope of word detailed in the quote from the contractor. see uploaded document, A summary involumoving an overbed light, instantification another overbed light, instantification and the call light can accommit two call light cords.  2. The residents to rooms 302, 400, 401, 402, 403, 40406, 410, 411 and 500 will be affected by this installations process. The contractor is planning to complete two roods. | for 12 0, 401, 0, 411 rk is ne lves stalling lling urtains; apter nodate 01, 14, 405, pe | 09/03/2022                        |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

residents.

Findings include:

Event ID:

4EQW21 Facility ID: 013420

complete the work.

If continuation sheet

3. A contractor has been hired to

Page 5 of 6

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2022 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER                           |  |   | (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       08/03/2022 |                     |  |            |                            |  |
|--|--|---|---|---------------------|--|------------|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER |  |   | STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619   |                     |  |            |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | TE         | (X5)<br>COMPLETION<br>DATE |  |
| TAG  | Based on observation 08/03/22 between resident sleeping rowere not equipped curtains. Based on observations, the Atrack and privacy crooms that are increbeds.  2) Based on observations are increbeds.  2) Based on observations are increbeds.  End of 20 resident sleep practice could affect findings include:  Based on observation on 08/03/22 between resident sleeping rowere equipped with instead of two call residents. Based on observations, the Administrator states | ons with the Maintenance rator, and Admissions Admin en 9:30 a.m. and 10:30 a.m., soms 400-406, 410, 411, 301, 302 with the track and privacy interview at the time of the dmissions Admin stated the urtains were on order for the 11 easing from one bed to two ation and interview, the facility excess for nurse call lights in 11 bing rooms. This deficient et 11 residents.  ons with the Maintenance rator, and Admissions Admin en 9:30 a.m. and 10:30 a.m., soms 400-406, 410, 411, 301, 302 in only one nurses call button buttons for rooms with two in interview at the time of the dmissions Admin and d there is only one nurses call ons that are increasing from |   | TAG                 | 4. The maintenance director a administrator will verify work the second completed, rooms will be verified for compliance for two residents. The maintenance director will report progress or item to QAPI until work is completed. | nnd<br>hat | DATE                       |  |
|  | The findings were reviewed with the Maintenance Director, Administrator, and Admissions Admin during the exit conference.  |   |   |                     |  |            |                            |  |
| 3.1-19(a)  |  |   |   |                     |  |            |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4EQW21 Facility ID: 013420 If continuation sheet Page 6 of 6