| STATEMENT OF DEPICIPACIEN N1 PROVIDERSUPPLIERCE IA DENTIFICATION NUMBER X2) MUIT THE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION ISS831 NUMBER X DULDING 01 MARE OF PROVIDER OR SUPPLIER STRIFT ADDESSES, TTX, STATL, ZP COD S024 WESTERN AVENUE SOUTH EEAD, IN 46619 MARE OF PROVIDER OR SUPPLIER STRIFT ADDESSE, TTX, STATL, ZP COD S024 WESTERN AVENUE COMPLETER SOUTH EEAD, IN 46619 SOUTH EEAD, IN 46619 COMPLETER AVENUE VAID THE ADDEVICENCY ON IS DE PRECEDED BY FULL RESULATION OF DEPICIPACING OF THE PRECEDED BY FULL RESULATION OF LISC DAVITY ING INFORMATION PREFIX TAG PROVIDER FLAOR OCCURATION OF DEPECTIVENT TAG PREFIX RESULATION OF DEPECTIVENT OF DEPECTIVENT TAG PREFIX RESULATION OF DEPECTIVENT OF DEPECTIVENT TAG PREFIX RESULATION OF DEPECTIVENT OF DEPECTIVENT TAG PREFIX RESULATION | | T OF HEALTH AND HU R MEDICARE & MEDIO | | | | | | FORM APPROVED OMB NO. 0938-039 | |
|---|--|--|--|----|--------|----------------------------------|-----|-----------------------------------|--|
| NAME OF PROVINER OF SLIPPLER 5024 WESTERN AVENUE BRIARCLIFF HEALTH & REHABILITATION CENTER 5024 WESTERN AVENUE (X) ID SUMMARY STATEMENT OF DEFICIENCE PRIFIX TAG REQUATORY OR LSC IDENTIFYING INFORMATION DRIFIN TAG REQUATORY OR LSC IDENTIFYING INFORMATION DRIFIN Bidg. 01 A Post Survey Revisit was conducted for the Procequarey survey that was conducted for the Procequarey survey that may conduced for the Procequarey survey that may conduced for the Procequare with 42 CFR 483.90(a) K 0000 Survey Date: 09/19/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 K 0000 A this PSR survey, Briarcliff Health and Rehabilitation CLSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type II (000) construction and was fally spriklered. The facility has a free atarm system with snoke detection in the corridors, all areas open to the corridor and hard ac ensus of 91 at the time of this survey. All areas where resident sheeping rooms. The facility has a capacity of 111 and had a census of 91 at the time of this survey. | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BUILDING <u>01</u> | | | (X3) DATE SURVEY COMPLETED | | | |
| CAD ID SUMMARY STATEMENT OF DEFICIENCIE ID INCREMENT INCREMENT <th></th> <th></th> <th></th> <th></th> <th>5024 W</th> <th>ESTERN AVENUE</th> <th></th> <th></th> | | | | | 5024 W | ESTERN AVENUE | | | |
| PRETX TAG (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PRETX TAG PRETX REGULATORY OR LSC IDENTIFYING INFORMATION COMPLE TAG Bidg. 01 A Post Survey Revisit was conducted for the Proceupancy survey that was conducted for the Deta increase of 2011/8/19 beds in rooms 400-411, 500, 506, 508, 510, 512, 514, 301 and 302 on 08/03/22 by the Indiana Department of Health in accordance with 42 CFR 483.90(a) K 0000 Complex Survey Date: 09/19/22 Complex Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 K 1000, 100, 100, 100, 100, 100, 100, 10 | | T | | | | I | | T | |
| TAG TAG TAG TAG TAG RGULATORY OR LSC IDENTIFYING INFORMATION TAG DEREMINENT DEPENDENTIFYING INFORMATION Bidg. 01 A Post Survey Revisit was conducted for the bed increase of 20 T1819 beds in rooms 400-411, 500, 506, 508, 510, 512, 514, 301 and 302 on 08:03:722 by the Indiana Department of Health in accordance with 42 CFR 483.90(a) K 0000 Survey Date: 09/19/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 2012 edition of the National Fire Protection and was fould not in compliance with Requirements for Participation in Medicard/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a capacity of 111 and had a census of 91 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. | | | | | | PROVIDER'S PLAN OF CORRECTION | | | |
| K 0000 Bldg. 01 A Post Survey Revisit was conducted for the Preocupancy survey that was conducted for the bed increase of 20 T18/19 beds in rooms 400-411, 500, 506, 508, 510, 512, 514, 301 and 302 on 08003/22 by the Indiana Department of Health in accordance with 42 CFR 483.90(a) K 0000 Survey Date: 09/19/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this PSR survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 840part (483.90(a), Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with snoke detection in the corridors, all areas open to the corridor and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 111 and had a census of 91 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. | | | | | | CROSS-REFERENCED TO THE APPROPRI | ATE | | |
| Bidg, 01 A Post Survey Revisit was conducted for the Preocupancy survey that was conducted for the bed increase of 20 T18/19 beds in rooms 400-411, 500, 506, 508, 510, 512, 514, 301 and 302 on 08/03/22 by the Indiana Department of Health in accordance with 42 CFR 483.90(a) K 0000 Survey Date: 09/19/22 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 A t this PSR survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a canceit of 111 and had a census of 91 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. | | REGULATORIO | R LSC IDENTIFTING INFORMATION | | IAU | | | DATE | |
| were sprinklered and all areas providing facility services were sprinklered. | K 0000 | A Post Survey Rev Preoccupancy surv bed increase of 20 500, 506, 508, 510 08/03/22 by the Ir accordance with 42 Survey Date: 09/1 Facility Number: Provider Number: AIM Number: 20 At this PSR survey Rehabilitation Cen with Requirements Medicare/Medicaid Life Safety from F National Fire Proto Life Safety Code (Health Care Occup This one-story faci determined to be o was fully sprinkler system with smoko areas open to the c detectors in all resi facility has a capad | visit was conducted for the rey that was conducted for the T18/19 beds in rooms 400-411, 0, 512, 514, 301 and 302 on adiana Department of Health in 2 CFR 483.90(a) 9/22 013420 155831 1293620 7, Briarcliff Health and ter was found not in compliance is for Participation in d, 42 CFR Subpart 483.90(a), ire, and the 2012 edition of the exction Association (NFPA) 101, LSC), Chapter 19, Existing pancies and 410 IAC 16.2. ility with a basement was f Type II (000) construction and ed. The facility has a fire alarm e detection in the corridors, all orridor and hard-wired smoke ident sleeping rooms. The city of 111 and had a census of | KO | | | | | |
| Quality Review completed on 09/21/22 | | were sprinklered a services were sprin | nd all areas providing facility hklered. | | | | | | |
| | | Quality Review co | mpleted on 09/21/22 | | | | | | |

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

TITLE

(X6) DATE

PRINTED: 08/31/2023

Any define cystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING | | | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 09/19/2022 | |
|---|--|---|--|--|--------|---|--|
| | PROVIDER OR SUPPLIE | R EHABILITATION CENTER | 5024 W | ADDRESS, CITY, STATE, ZIP CO /ESTERN AVENUE I BEND, IN 46619 | D | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| K 0363 SS=E Bldg. 01 | NFPA 101 Corridor - Doors Corridor - Doors Doors protecting than required en- exits, or hazardo of smoke and are solid-bonded cor capable of resisti minutes. Doors in compartments ar passage of smok to rooms contain combustible math hardware. Roller CMS regulation. apply to auxiliary flammable or cor Clearance betwe covering is not et doors complying if provided with a the door closed w applied. There is closing of the door release when the permitted. Nonra unlimited height a meeting 19.3.6.3 frames shall be is other materials in unless the smoke sprinklered. Fixe allowed per 8.3. there are no rest resistance of glas assemblies. | corridor openings in other closures of vertical openings, us areas resist the passage e made of 1 3/4 inch e wood or other material ing fire for at least 20 in fully sprinklered smoke re only required to resist the te. Corridor doors and doors ing flammable or erials have positive latching latches are prohibited by These requirements do not spaces that do not contain inbustible material. en bottom of door and floor kceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is a no impediment to the ors. Hold open devices that e door is pushed or pulled are ted protective plates of are permitted. Dutch doors .6 are permitted. Door abeled and made of steel or in compliance with 8.3, | | | | | |

PRINTED: 08/31/2023

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831 | | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION <u>01</u> | (X3) DATE SURVEY COMPLETED 09/19/2022 | |
|--|---|---|---------------------------|---|---|
| NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER | | | STREET 5024 V SOUTI | | |
| X4) ID PREFIX TAG | (EACH DEFICIE | ' 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 APPROPRIAT DEFICIENCY) | TE (X5) COMPLETION DATE |
| | Show in REMAR fire protection rat devices, etc. Based on observat failed to ensure 1 of corridor doors was for keeping the doo closing, latching a smoke. This defic residents in room 4 Findings include: Based on observat 09/19/22 at 1:37 p room 409 did not 1 several times by th on interview at the Administrator state scheduled to fix th the door didn't latce This finding was re Administrator duri | KS details of doors such as ings, automatics closing ion and interview, the facility of at least 40 resident room provided with a means suitable or closed, had no impediment to and would resist the passage of ient practice could affect 2 409. ion Interim Administrator on .m., the corridor door to resident atch into the frame when tested tatch into the frame when tested time of observation, the Interim ed that Maintenance was e door and she wasn't sure why h into the door frame. eviewed with the Interim ng the exit conference. as cited on 08/03/22. The facility tt a systemic plan of correction | K 0363 | K363 What corrective actions will be accomplished for those resider found to have affected by the deficient practice; The one identified latch on th corridor door (room 409) was repaired/adjusted and now latches properly as required. How the facility will identify other resident having the potential to affected by the same deficient practice and what corrective active will be taken; All doors protecting the corridor openings will be inspected to ensure that alldoors protecting corridor openings will be smoke resistive; have no impediment to closing; are self-latching a provided with positive latching hardware What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recu Ongoing, the Administrator of designee will monitor corrido doors to ensure continued compliance. How will the corrective action b monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will put into place; Results of the monitoring will | er be ction hts nd ng be ss cur: r or or or ope ent t ll be |

PRINTED: 08/31/2023

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831 | | IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 09/19/2022 | |
|--|---|---|--|--|--|--------------------|
| NAME OF | PROVIDER OR SUPPLIE | R | | ET ADDRESS, CITY, STATE, ZIP COD | | |
| BRIARC | LIFF HEALTH & RE | EHABILITATION CENTER | | WESTERN AVENUE TH BEND, IN 46619 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | N | (X5) |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE RIATE | COMPLETION DATE |
| | | | | be reviewed during the facility's Quality Assuranc meeting; monitoring will be ongoing. | | |
| < 9999 | | | | | | |
| Bldg. 01 | 3.1-19 ENVIRON | MENT AND PHYSICAL | K 9999 | What corrective actions will | be | 10/24/2022 |
| | 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 n to receive resident system from the re This State Rule has Based on observati failed to provide pin residents. This def least 9 residents. Findings include: Based on observati Administrator on C | ity must be designed, ped, and maintained to protect ty of residents, personnel, and of in private rooms, each bed suspended cubicle curtains or oof or flame-retardant material, nd the bed to provide total combination with adjacent walls urses' station must be equipped calls through a communication sident rooms. s not been met as evidenced by: ion and interview, the facility rivacy curtains in 9 of 20 poms containing at least 2 ficient practice could affect at ions with the Interim 19/19/22 between 1:20 p.m. and pwing resident rooms were not | | accomplished for those reside found to have affected by the deficient practice; The privacy curtains and he have been ordered and will installed when we receive them. How the facility will identify or resident having the potentia affected by the same deficient practice and what corrective will be taken; An audit was completed arr only the 11 rooms that werr identified during the surve were found to be missing. What measures will be put i place or what systemic charr will be made to ensure that deficient practice does not resident practice does not resident practice does not resident practice does not resident practice does not resure the deficient practice does not resure the deficient practice does not resure the deficient practice will monitor all required rooms to ensure continued compliance. How will the corrective action monitored to ensure the deficient practice will not recur, i.e. will assurance programs put into place; | e nooks I be other I to be ent e action nd re y nto nges the ecur: r or n be icient hat | |

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

Event ID: 4EQW22 Facility ID: 013420

If continuation sheet Page 4 of 5

PRINTED: 08/31/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155831 B. WING 09/19/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **5024 WESTERN AVENUE BRIARCLIFF HEALTH & REHABILITATION CENTER** 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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE required: 301, 302, 400, 401, 404, 403, 405, 407, 410, be reviewed during the 411, and 500. Based on interview with the Interim facility's Quality Assurance Administrator at the time of the observations, the meeting; monitoring will be hooks and additional privacy curtains are on ongoing. order. This finding was reviewed with the Interim Administrator during the exit conference. This deficiency was cited on 08/03/22. The facility failed to implement a systemic plan of correction to prevent recurrence.

4EQW22 Facility ID: 013420

If continuation sheet

Page 5 of 5

PRINTED:

08/31/2023