

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 03/18/24</p> <p>Facility Number: 013302 Provider Number: 155824 AIM Number: 201281730</p> <p>At this Emergency Preparedness survey, Wellbrooke of South Bend was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 70 certified beds. At the time of the survey, the census was 38.</p> <p>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:</p> <p>Quality review conducted on 03/20/24</p>			E 0000	<p>The submission of this plan of correction does not indicate an admission by The Wellbrooke of South Bend that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents by The Wellbrooke of South Bend. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>		
E 0015 SS=F Bldg. --	<p>403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1)</p> <p>Subsistence Needs for Staff and Patients</p> <p>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)</p> <p>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph</p>						

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

TITLE

(X6) DATE

Karl Steinhaus

Executive Director

03/30/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 30 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.

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(i) Food, water, medical and pharmaceutical supplies</p> <p>(ii) Alternate sources of energy to maintain the following:</p> <p>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health</p>						

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's EPP with the Director of Plant Operations (DPO) on 03/18/24 between 10:38 a.m. and 2:23 p.m., when asking the DPO to provide policies for food, water, medical and pharmaceutical supplies in the event of an evacuation or shelter-in-place event, the DPO was unable to locate the policies within the EPP. Furthermore, when the DPO was asked to verbally discuss the process to maintain the supplies for the aforementioned supplies during an evacuation or shelter-in-place emergencies, he was unable to discuss the proper procedures in that situation. The surveyor was able to locate the missing policies in the EPP. The DPO did not demonstrate the proper knowledge of the EPP.</p>			E 0015	<p>E015 – Subsistence Needs for Staff and Patients Compliance Date 4/12/2024 <b>Immediate Intervention</b> The Director of Plant Operations reviewed the Emergency Operations Plan (EOP) in its entirety, to include policies for food, water, medical and pharmaceutical supplies. The Director of Plant Operations was Educated by the Executive Director on E015, Subsistence Needs for Staff and Patients. Education will need to be provided by the ED and signed by ED/DPO. The Director of Plant Operations will review the Emergency Operations Plan (EOP) and the policies within it to ensure proper knowledge of the EOP and will be able to discuss the procedures during an evacuation or shelter-in-place emergency. 1 X Per Month X 6 Month Create and start an audit tool. This will need to have the signature of the DPO. Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines</p>		04/12/2024

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0037 SS=F Bldg. --	<p>The finding was reviewed with the Director of Plant Operations during the exit conference.</p> <p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p>				<p>substantial compliance has been achieved.</p> <p>This deficient practice could affect all occupants.</p>		

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p>						

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p>						

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p>						

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., no documentation of annual EPP</p>			E 0037	<p>E037 – EP Training Program Compliance Date 4/12/2024 <b>Immediate Intervention</b> The Director of Plant Operations completed an all staff, individuals providing services under arrangement, and volunteers annual training of the Emergency Operations Plan (EOP) and the procedures. Provide a copy of the training with signatures. The Director of Plant Operations was Educated by the Executive Director on E037, EP Training Program must do all the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their</p>		04/12/2024



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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 0000  Bldg. 01	<p>training nor documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Director of Plant Operations indicated that the training done related to the emergency preparedness is done with fire/tornado drills and the exercises that are required to be conducted. The Director of Plant Operations then acknowledged no other documentation is available to show that staff can demonstrate knowledge on the EPP.</p> <p>This finding was reviewed with the Director of Plant Operations during the exit conference.</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 03/18/24</p> <p>Facility Number: 013302</p>		K 0000	<p>expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. Provide a copy of the education. The Director of Plant Operations will conduct an audit 1 X per Month X 6 Month of the annual Emergency Operations Plan (EOP) documentation assuring that all staff, individuals providing services under arrangement, and volunteers have completed the training. Provide a copy of the audit. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants.</p> <p>The submission of this plan of correction does not indicate an admission by The Wellbrooke of South Bend that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to</p>			

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Provider Number: 155824 AIM Number: 201281730</p> <p>At this Life Safety Code survey, Wellbrooke of South Bend, 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.</p> <p>This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a horizontal floor/ceiling assembly with a 2-hour Fire Resistive Rating. The rated floor/ceiling system is supported by 2 hour rated construction. The Southwest wing of the first floor is a residential occupancy, however is not separated from the healthcare facility by a 2-hour fire barrier, and is therefore surveyed as healthcare. Furthermore, an activities room is located on the second floor which was stated healthcare residents use periodically which was also surveyed under healthcare. The building is partially protected by a 300 kW natural gas powered generator. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 38 at the time of this visit.</p>				the residents by The Wellbrooke of South Bend. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.		

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0161 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review conducted on 03/20/24</p> <p>NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section</p>						

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type in 1 of over 60 rooms. This deficient practice could affect approximately 20 residents and staff.</p> <p>Findings include:</p> <p>Based on observations with the Director of Plant Operations during a tour of the facility from 2:24 p.m. to 4:16 p.m. on 03/18/24, within mechanical room labeled B153, an approximate 4 inch pipe went through the ceiling in which an observed 1/4" penetration was noted between the pipe and ceiling. Based on interview during observation, the Director of Plant Operations confirmed the ceiling penetration and noted fire caulk must have came dislodged.</p> <p>This finding was reviewed with the Director of Plant Operations at the exit conference.</p> <p>3.1-19(b)</p>			K 0161	<p>K161 – Building Construction Type and Height Compliance Date 3/29/2024 <b>Immediate Intervention</b> The Director of Plant Operations as completed the repair to the ¼ inch penetration between the pipe and the ceiling located within the mechanical room labeled B163 with approved Fire Caulk. Provide a photo of the repair. The Director of Plant Operations was Educated by the Executive Director on K161, NFPA 101, 2012 Edition, 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 Provide a copy of the education. The Director of Plant Operations will complete a one-time audit of the facility assuring that all penetrations of piping and wiring are properly sealed with approved fire caulking. This audit will be followed by a visual audit of the facility 1 X per Month X 3 Months that all penetrations of piping and wiring are properly sealed. Provide a copy of the Audit. Results of this audit and visual</p>		03/29/2024

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0345 SS=F Bldg. 01	<p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> <li>a. Control unit trouble signals</li> <li>b. Remote annunciators</li> <li>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)</li> <li>d. Notification appliances</li> </ul>	K 0345	<p>inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect approximately 20 residents and staff.</p> <p>K345 – Fire Alarm System – Testing and Maintenance Compliance Date 4/12/2024 <b>Immediate Intervention (1)</b> The Director of Plant Operations has scheduled contractor, New Era, to complete visual inspection of the fire alarm system on 4/9/24-4/10/24. The Director of Plant Operations has also scheduled training on visual inspection of the fire alarm system with Facilities Management Support 4/4/24. You will need to contact Jamie Monday to get this scheduled. We need to change the date on this one.</p>	04/12/2024	

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>e. Magnetic hold-open devices This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>During record review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 06/29/23. Based on interview at the time of records review, the Director of Plant Operations stated that a new template had been created for visual inspections of the fire alarm, however no training has been conducted on it and has not been completed.</p> <p>This finding was reviewed with the Director of Plant Operations at the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3.</p>				<p>Provide copies of the training. Copy of the visual inspection. Can we provide a copy of the communication with Koorsen showing that this inspection is scheduled.</p> <p>The Director of Plant Operations was Educated by the Executive Director on K345, Fire Alarm System – Testing and Maintenance , NFPA 101, 2012 Edition 19.3.4.5.1 and 9.6.1.3A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. Provide a copy of the education.</p> <p>/p&gt; Results of this review and visual inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants. Compliance Date __/__/____ Immediate Intervention (2) The Director of Plant Operations has scheduled contractor, New Era, to complete sensitivity inspection of the fire alarm system</p>		

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	<p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., the latest documentation of a sensitivity test for the fire alarm system was dated 03/26/21. Sensitivity testing should have been conducted again around 03/2023 respectively. Based on interview at the time of record review, the Director of Plant Operations acknowledged that updated sensitivity testing was overdue and no other documentation was found during the survey. This finding was reviewed with the Director of Plant Operations at the exit conference. 3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  Provide in REMARKS information on</p>				<p>on 4/9/24- 4/10/24. Copy of the testing. The Director of Plant Operations was Educated by the Executive Director on NFPA 72,14.4.5.3.2 smoke detector sensitivity shall be checked every other year. Copy of the education /p&gt; Results of this review and visual inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all occupants. K353 – Sprinkler System – Maintenance and Testing</p>		

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on observation and interview, the facility failed to ensure 4 of 5 sprinkler heads in laundry and 8 of 10 sprinkler heads in the kitchen were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 10 staff and an unknown number of residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Operations on 03/18/24 between 2:24 p.m. and 4:16 p.m. the following sprinkler heads were coved in dust or showed signs of loading;</p> <p>a) Eight sprinkler heads within the kitchen area had signs of corrosion and green foreign matter on the sprinkler head and 1 sprinkler head next to the prep station and one within the dry storage room within the kitchen were excessively loaded with dirt and foreign debris.</p> <p>b) Four sprinkler heads in the laundry room above the washers and one above the dryer were covered with dust and lint.</p> <p>Based on interview at the time of observations, the Director of Plant Operations confirmed the</p>			K 0353	<p>K353 – Sprinkler System – Maintenance and Testing Compliance Date 4/12/2024 Immediate Intervention</p> <p>The Director of Plant Operations and the Senior Director of Plant Operations will clean the 4 sprinkler heads located in laundry covered in dust and lint. The remaining 9 sprinkler heads will be replaced by Koorsen (contractor). Note: We will need a date for the replacement.... WE will need photos of the cleaned heads and documentation of scheduled repairs from the vendor.</p> <p>The Director of Plant Operations was Educated by the Executive Director on K353, NFPA 101, 2012 Edition 9.7.5 NFPA 25, 2011 Edition. Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. Copy of Education.</p> <p>The Director of Plant Operation will</p>		04/12/2024



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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	<p>aforementioned sprinkler heads showed corrosion and were loaded with foreign debris.</p> <p>Findings were discussed with the Director of Plant Operations at exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p>				<p>conduct a one-time visual inspection of the facility assuring sprinkler heads do not show signs of Leakage, corrosion, physical damage, Loss of fluid in the glass bulb, loading, or painted. Any sprinkler found in the condition listed will be replaced. This Inspection will be followed with an audit of the sprinkler heads in the facility conducted 1 X per Quarter X 4 Quarters Copy of audit.</p> <p>Results of the audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect approximately 10 staff and an unknown number of residents.</p>		

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions for all shifts for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Director of Plant Operations (DPO) on 03/18/24 between 10:38 a.m. and 2:23 p.m., multiple fire drills throughout the past 12 months have been conducted between the 28th and 31st of the month in each quarter. This condition does not allow fire drills to be conducted at unexpected times. Based on interview at the time of record review, the Director of Plant Operations agreed that most fire drills are being conducted around the indicated dates and are not varying in dates.</p> <p>This finding was reviewed with the Director of Plant Operations during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>			K 0712	<p>K712 – Fire Drills Compliance Date 4/12/2024 <b>Immediate Intervention</b> The Director of Plant operation has conducted and documented an unannounced Fire Drill on each shift Note: Need date. The Director of Plant Operations was Educated by the Executive Director on K712, NFPA 101, 2012 Edition, 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. Copy of education</p> <p>The Director of Plant Operation has created a monthly audit tool with pre-scheduled fire drills with varying times for the following 12 months. Copy of audit.</p> <p>Results of the audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff, and visitors in the facility.</p>		04/12/2024

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0761 SS=F Bldg. 01	<p>1. Based on record review and interview, the facility failed to ensure annual inspection and testing of 27 of 27 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:</p> <p>(1) No open holes or breaks exist in surfaces of either the door or frame.</p> <p>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.</p> <p>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances</p>			K 0761	<p>K712 – Fire Drills Compliance Date 3/29/2024 <b>Immediate Intervention</b> The Director of Plant operation has conducted and documented an unannounced Fire Drill on each shift Note: Need date. The Director of Plant Operations was Educated by the Executive Director on K712, NFPA 101, 2012 Edition, 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. Copy of education</p> <p>The Director of Plant Operation has created a monthly audit tool with pre-scheduled fire drills with varying times for the following 12 months. Copy of audit.</p> <p>Results of the audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff, and visitors in the facility.</p>		03/29/2024

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(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
	<p>listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., inspection documentation for 27 fire door assemblies were last dated 01/23/23. No other documentation could be found during the survey that confirmed all fire door assemblies have been inspected within the past 12 months. Based on interview at the time of record review, the Director of Plant Operations agreed that the fire door assemblies have not been inspected this year and was planning on doing the inspection later this month.</p> <p>Findings were discussed with the Director of Plant Operations at exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review, and interview; the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of</p>						

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	<p>NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect approximately 10 staff and an unknown number of residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Operations on 03/18/24 between 2:24 p.m. and 4:16 p.m., there was one rolling fire door separating the service hall and a storage area. During record review between 10:38 a.m. and 2:23 p.m., the last documented inspection was from 01/17/23. Based on interview at the time of record review, the Director of Plant Operations confirmed that the inspections were over 12 months old and that a rolling fire door was located within the facility.</p> <p>Findings were discussed with the Director of Plant Operations at exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable</p>						

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>1. Based on record review and interview, the facility failed to document the transfer time to the alternate power source on the monthly load tests for 12 of the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff and visitors.</p>	K 0918	<p>K918 – Electrical Systems – Essential Electrical System Maintenance and Testing. Compliance Date 4/12/2024</p> <p><b>Immediate Intervention (1)</b></p> <p>The Director of Plant Operations has completed a monthly exercise of the generator, under load. The</p>		04/12/2024		

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Findings include:</p> <p>Based on record review on 03/18/24 between 10:38 a.m. and 2:23 p.m. with the Director of Plant Operations, the Weekly/Monthly Generator Log were reviewed over the past year and lacked the transfer time from normal power to emergency power. Based on interview at the time of record review, the Director of Plant Operations confirmed that transfer times are not documented on the monthly test sheets.</p> <p>Findings were discussed with the Director of Plant Operations at exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on records review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., no documentation for a fuel analysis test within the past 12 months was available for review. Based on interview at the time of record</p>				<p>completed documentation includes the transfer time to the alternate source of power. Copy of the load test.</p> <p>The Director of Plant Operations was Educated by the Executive Director on K918, NFPA 101, 2012 Edition. The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds.</p> <p>The Director of Plant Operation will review 1 X per monthly X 3 months the documentation and results of the generator load testing. Copy of the audit</p> <p>The results of the review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p><b>Immediate Intervention (2)(3)(4)</b></p> <p>The Director of Plant Operation has located and verified the documentation for the fuel analysis, coolant heater repair, coolant service, and load bank conducted by Cummins in October of 2023.</p> <p>The Director of Plant Operations was Educated by the Executive Director on K918, NFPA 110, section 8.3.8. Fuel quality tests</p>		

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>review, the Director of Plant Operations stated paperwork provided during the survey was the available paperwork he had and had no other documentation to confirm if a fuel test has been done within the past 12 months.</p> <p>This finding was reviewed with the Director of Plant Operations at the exit conference.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure the continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., the generator service report from 09/18/23 stated the emergency generator was found to have a bad coolant heater along with servicing of the coolant system. Based on interview at the time of record review, the Director of Plant Operations indicated that the repairs may have been done, however no documentation during the survey could be presented to confirm if repairs had been made.</p> <p>The finding was reviewed with the Director of Plant Operations during the exit conference.</p> <p>3.1-19(b)</p> <p>4. Based on record review and interview, the facility failed to exercise 1 of 1 generators annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2</p>				<p>shall be performed at least annually using tests approved by ASTM standards.</p> <p>The Director of Plant Operation will review 1 X per monthly X 3 months the documentation and results of the generator inspection and testing.</p> <p>The results of the review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect all residents, staff, and visitors in the facility.</p>		



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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., the Weekly/Monthly inspection documented that the diesel emergency generator runs under 30% load every load test. A load bank test documentation had been located during the survey, however it was dated 01/05/21. Based on interview at the time of record review, the Director of Plant Operations confirmed that all documentation he had were presented during the survey and was unsure where any updated documents could be located.</p> <p>Findings were discussed with the Director of Plant Operations at exit conference.</p>						

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strip was not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 10 residents and staff.</p>			K 0920	<p>K920 – Electrical Equipment – Power Cords and Extension Cords. Compliance Date 3/29/2024 The Director of Plant Operations has removed the unapproved power strip located in the memory care unit used to power the refrigerator. The Director of Plant Operations</p>		03/29/2024

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

PRINTED: 04/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155824		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 03/18/2024	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP COD 52565 STATE ROAD 933 SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations on 03/18/24 between 10:38 a.m. and 2:23 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Memory care wing within the dining area. Based on interview at the time of observation, the Director of Plant Operations was unaware of the power strip and would work on getting the power strip removed.</p> <p>Findings were discussed with the Director of Plant Operations at exit conference.</p> <p>3.1-19(b)</p>				<p>was Educated by the Executive Director on K920 10.2.3.6 Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. As it pertains to 10.2.4, 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70 - 2011), 590.3 (D) (NFPA70), TIA 12-5.</p> <p>The Director of Plant Operations will perform a one-time audit of the facility and remove all unapproved power strips. This will be followed with a weekly audit X 3 months of the facility assuring that there isn't the use of unapproved power strips in the facility.</p> <p>The results of the audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>This deficient practice could affect approximately 10 residents and staff.</p>		