STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155824	A. BUILDING -- B. WING	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	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. --	A Post Survey Revisit (PSR) for the Emergency Prepardness Survey that exited on 03/18/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73 Survey Date: 04/29/24 Facility Number: 013302 Provider Number: 155824 AIM Number: 201281730 At this Emergency Preparedness PSR, Wellbrooke of South Bend was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 70 certified beds. At the time of the survey, the census was 41. Quality Review completed on 05/02/24	E 0000	The submission of this plan of correction does not indicate an admission by 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 of 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. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/18/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 04/29/24 Facility Number: 013302	K 0000	The submission of this plan of correction does not indicate an admission by 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 of Wellbrooke of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karl Steinhaus	Executive Director	05/17/2024

Any defiencystatement 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.

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	Provider Number: 155824 AIM Number: 201281730 At this Life Safety Code PSR, 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. 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 41 at the time of this visit.		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. The facility respectfully requests from the department a desk review for substantial compliance.	

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/02/24			
K 0761 SS=F Bldg. 01	Based on record review and interview, the facility failed to ensure annual inspection and testing of 7 of 12 fire door assemblies were completed in accordance with 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: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and	K 0761	**K761-Maintence, Inspection & Testing-Doors Compliance Date-5/1/2024Immediate intervention (1)The director of Plant Operations completed a full annual inspection of 12 of 12 fire door assemblies in facility 4/29/2024.The Director of Plant Operations was educated by Executive Director on K761, NFPA 101, 2012 edition, NFPA 80, 5.2.1 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 AHJ.The Director of Plant Operations has completed a full inspection of 12 of 12 fire doors in the facility. This inspection will be continued annually with a due date of 3/24 of the consecutive year.Results of the inspection will be presented by the Executive Director to the QAPI committee for further recommendations and continue to follow on QAPI.This**	04/30/2024

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	noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Director of Plant Operations and Executive Director on 04/29/24 between 10:35 a.m. and 10:50 a.m., fire door inspection documentation titled "Annual Inspection of Swinging Fire Door Assemblies" dated 03/25/24 indicated that five fire wall doors were inspected. However, the facilities stairwell doors and oxygen room were not listed on the inspection documentation. Based on interview at the time of record review, the Director of Plant Operations acknowledged that the documentation lacked door inspections and stated he was unaware that those doors were to be included in the inspections. Based on observation during a tour of the facility between 10:51 a.m. and 11:50 a.m., the facility had approximately six stairwell		**deficient practice could affect all residents, staff and visitors in the facility.**	

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	doors were listed with a fire resistance rating of 1-1/2 hours. Furthermore, the oxygen transfilling/storage room had a fire resistance rating of 45 minutes. Findings were discussed with the Director of Plant Operations and Executive Director at exit conference. This deficiency was cited on 03/18/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3.1-19(b)			
K 0918 SS=F Bldg. 01	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 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. 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			

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	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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. 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 NFPA110, 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. Findings include: Based on records review with the Director of Plant Operations and Executive Director on 04/29/24 between 10:35 a.m. and 10:50 a.m., no documentation for a fuel analysis test within the past 12 months was available for review. During record review, an email was provided which stated the generator company is going to be out next month to conduct a service which includes a load bank and sampling of the fuel and oil sample. Based on interview at the time of record review, the Director of Plant Operations confirmed that	K 0918	**K918 – Electrical Systems – Essential Electrical System Maintenance and Testing. Compliance Date 5/15/2024Immediate Intervention (1)The Director of Plant Operations has completed a monthly exercise of the generator, under load. The completed documentation includes the transfer time to the alternate source of power. Copy of the load test.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.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 auditThe results of the review will be presented by the Executive Director to the QAPI committee for further**	05/15/2024

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	the generator company is coming out in May to conduct the missing inspections which have not been completed yet. The Maintenance Director stated that the sample and load bank have not been conducted within the past year. This finding was reviewed with the Director of Plant Operations and Executive Director at the exit conference. This deficiency was cited on 03/18/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 3.1-19(b) 2. 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 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: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (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.		**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.Immediate Intervention (2)(3)(4)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.The Director of Plant Operations was Educated by the Executive Director on K918, NFPA 110, section 8.3.8. Fuel quality tests shall be performed at least annually using tests approved by ASTM standards.The Director of Plant Operation will review 1 X per monthly X 3 months the documentation and results of the generator inspection and testing.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.This deficient practice could affect all residents, staff, and visitors in the facility.**	

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	Findings include: Based on records review with the Director of Plant Operations and Executive Director on 04/29/24 between 10:35 a.m. and 10:50 a.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 the missing documentation and further clarified that the load bank, along with other inspections, were going to be completed within a few weeks. An email provided during record review from the generator company did state that they were going to be completing a 2-hour load bank test on May 15th. The Director of Plant Operations did state that it is being completed due to not being done last year. Findings were discussed with the Director of Plant Operations and Executive Director at exit conference. This deficiency was cited on 03/18/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences 3.1-19(b)			