STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 4, 5, 6, 7, and 8, 2023 Facility number: 000246 Provider number: 155355 AIM number: 100275420 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 5 Medicaid: 45 Other: 10 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 12/20/2023.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity, this provider respectfully requests that this 2567 Plan of Correction be considered for a desk review in lieu of a post survey revisit.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical			

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

Greg Schiavone 12/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure that a Physician Order indicated a Do Not Resuscitate (DNR) as indicated upon admission by the resident and legal representative for 1 of 2 residents reviewed for Advance Directives (Resident 43).	F 0578	**F578 Request, refuse, discontinue treatment, formulate advanced directives** It is the practice of this facility to ensure that residents have the right to request, refuse, and/or discontinue treatment, to	01/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	Finding includes: A record review was completed, on 12/07/2023 at 8:43 A.M., and indicated diagnoses included, but were not limited to: Alzheimer's disease, dysphagia, anxiety, and depression. A current Physician's Order, dated 3/28/2023, indicated Resident 43 had a Full Code status ordered. A signed POST (Physician's Orders for Scope of Treatment) form dated 9/7/2023 indicated Resident 43 had a Do Not Resuscitate status. A care plan, dated 9/29/2023, indicated Resident 43's legal representative had formulated a Do Not Resuscitate with POST orders. Resident and legal representative preferences regarding advanced directives would be honored. Assess for change in condition as indicated and ensure that the POST form would be completed fully and integrated in Physician's Orders and ensure that POST form is sent to the hospital with resident if hospitalized. During an interview, on 12/07/2023 at 10:11 A.M., LPN (Licensed Practical Nurse) 6 indicated that there was a discrepancy between the Physician's Order for Resident 43's code status and the POST form. LPN 6 indicated she was unsure why there was a discrepancy and indicated Resident 43 had been admitted as a Full Code status and the orders should have been updated when the POST form was changed. LPN 6 indicated that the orders and the POST form should have been the same. On 12/8/2023 at 9:00 A.M., the Director of Nursing provided a policy titled "Advanced Directives-POST, DNR, Health Care Rep" dated 1/2016 and indicated this was the current policy used by the facility. The policy indicated " ...If a		formulate an advanced directive and that this is provided to residents consistent with professional standards of practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 43's physician order was updated to reflect resident/POA's advanced directive wishes. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. An audit of all residents advanced directives and code status orders will be completed. Any findings will be reviewed with resident/POA, MD, and orders will be updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses and social services will be reeducated on reviewing and updating advanced directives per resident and/or POA wishes by DNS/designee. Advanced directives will be reviewed and updated including orders upon admission, quarterly, and as needed per resident/POA request and with changes in condition by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	resident has a valid Advanced Directive, the facility's care will reflect the resident's wishes as expressed in the Directive, in accordance with state law ...(2) Information about any Advanced Directives already in place will be gathered as part of the admission process. Executed Advanced Directives will be documented in the medical record. Advanced Directives which reflect medical care and treatment will be documented as a physician's order ...Implementing/Maintaining a POST form...(3) If the individual decides to revoke or change the POST form, the resident's attending physician should be notified and appropriate changes to the physician's orders should be obtained as soon as possible to ensure that the resident's wishes are accurately reflected in the plan of care ...." 3.1-4(5)		DNS/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “advanced directives” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to create a person-centered care plan for 2 of 25 residents whose care plans were reviewed (Residents 1 and 55).	F 0656	**F 656 – Develop/Implement Comprehensive Care Plan** **What Corrective action(s) will be accomplished for those residents found to have been**	01/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	Findings include: 1. A record review was completed on 12/7/2023 at 11:39 A.M. Resident 1's diagnoses included, but were not limited to: anxiety disorder, Non-Alzheimer's dementia, pseudobulbar affect, adjustment disorder with mixed anxiety and depressed. Resident 1's current physician orders included, but were not limited to: Lexapro 20 mg (milligram) tablet oral once a day for depression, and Valium 2 mg tablet 3 times a day for anxiety disorder. A current care plan, dated 2/24/2017, and revised, on 8/22/2018, indicated Resident 1 was displaying signs and symptoms of depression, such as trouble sleeping, feeling tired and having little energy, crying, and tearfulness. Resident 1 indicated she felt bad about herself and had trouble concentrating. Interventions included, but were not limited to: Offer encouragement and support to the the way Resident 1 feels, encourage activities of interest, encourage family support, and involvement. During an interview, on 12/7/2023 at 3:45 P.M., the Director of Nursing indicated Resident 1's care plan was not person centered, but should have been. 2. A record review was completed on 12/6/2023 at 3:42 P.M. Resident 55's diagnoses included, but were not limited to anxiety, depression, dementia and traumatic brain dysfunction. A Quarterly MDS (Minimum Data Set) assessment, dated 9/26/2023, indicated Resident 55 had no mood or behavior issues.		**affected by the deficient practice:** It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan consistent with the resident's goals and preferences. The care plan for residents 1 and 55 has been reviewed and updated to include a person-centered care plan for depression, anxiety, and psychotropic medications. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. An audit of all residents Comprehensive Care Plans related to depression, anxiety, and psychotropic medications will be completed and updated appropriately. Comprehensive Care Plan meetings will be held to ensure care plans are consistent with the resident's goals and preferences. All residents receiving antidepressant and antianxiety medication care plans were reviewed to ensure care plan addressed the medication. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Comprehensive Care Plan reviews will be completed by social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	Resident 55's current medication list included, but were not limited to: Lexapro (Antidepressant) and Lorazepam (Benzodiazepines). A current care plan, dated 6/13/2023, indicated the resident was at risk for signs and symptoms of anxiety. Worried facial expressions, repetitive movements, insomnia, reports of anxiety. Resident may become verbally aggressive with other residents. Has a diagnosis of Generalized Anxiety disorder. The interventions included: Encourage activities of interest. Encourage family support and involvement. Encourage resident to verbalize fears and anxiety, offer validation and reassurance. Maintain calm environment, move to quiet area. Medications per MD order, and Psych (psychiatric) services as appropriate- resident declined. A current care plan, dated 6/13/2023, and last reviewed on 10/2/2023, indicated the resident was at risk for signs/symptoms of depression. Sad facial expression, withdrawal, decreased appetite, tearfulness, insomnia, verbalization of depression, etc. PHQ-9 (Patient Health Questionnaire) states feeling tired and feeling fidgety/restless. The interventions included: Encourage activities of interest. Encourage family support ad involvement. Allow the resident to express feelings and frustrations offer validation and support. During an interview, on 12/8/2023 at 12:00 P.M., the Director of Nursing indicated the care plans were not person centered with interventions and should have been. On 12:10 P.M., the Director of Nursing provided the policy titled," IDT Comprehensive Care Plan		service/designee for all residents who receive antidepressant and antianxiety medication upon Admissions and quarterly thereafter and any change in condition involving the prescription of antianxiety and antidepressant medication. Social services and MDSC will be reeducated related to person centered care plans for residents receiving antianxiety and antidepressant medication by regional social wellness and enrichment support. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	Policy". The policy indicated"...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person--centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences...." 3.1-35(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen was provided as ordered, change oxygen equipment and ensure oxygen equipment was dated for 1 of 1 resident reviewed for oxygen use (Resident 52). Finding includes: During an observation, on 12/04/2023 at 11:45 A.M., Resident 52 had undated oxygen tubing and an undated humidification bottle in her room and the oxygen storage bag was dated 11/10/2023. During an observation, on 12/05/2023 at 9:11 A.M., Resident 52 had undated oxygen tubing	F 0695	**F695 Respiratory/Tracheostomy Care** It is the practice of this facility to ensure residents receive respiratory care in accordance with professional standards, comprehensive plan of care, and residents' preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 52 received new tubing and humidification bottle that were	01/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	and an undated humidification bottle in her room and the oxygen storage bag was dated 11/10/2023. During an observation, on 12/6/2023 at 5:55 A.M., no date was found on the oxygen tubing and the humidification bottle was undated and the oxygen tubing bag was dated 11/10/2023. During an observation, on 12/06/223 at 11:18 A.M., no date was on the oxygen tubing or humidification bottle and oxygen storage bag dated 11/10/2023 with staff observed in resident's room. During an interview, on 12/06/2023 at 3:06 P.M., LPN 5 indicated that Resident 52's oxygen tubing and humidification bottle should have been changed and dated on Sunday night per the Physician Order. LPN 5 looked at the oxygen tubing, humidification bottle, and oxygen storage bag and indicated that the oxygen tubing and humidification bottle should have been dated, and the bag should have been changed at the same time. LPN 5 indicated that the oxygen bag was dated 11/10/2023 and should have been changed out. A record review was completed, on 12/07/2023 at 11:10 A.M., and indicated Resident 52's diagnoses included, but were not limited to: chronic respiratory failure with hypoxia, dementia, cor pulmonale, pulmonary hypertension due to lung diseases and hypoxia. A Physician's Order, dated 5/12/23, indicated to change oxygen tubing and humidification bottle, and clean concentrator and filter once a week on Sunday. A Physician's Order, dated 7/19/2023, indicated		dated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. A facility audit will be completed by DNS/designee for all residents that require oxygen. All residents identified in this audit will be reviewed and all tubing and humidification bottles are dated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on dating oxygen tubing and humidification bottles on or before 1/7/23. Any resident requiring oxygen will be reviewed daily by the DNS/designee to ensure equipment is dated and bagged when not in use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	Resident 52 had continuous oxygen at two liters per nasal cannula. On 12/8/2023 at 9:00 P.M., the Director of Nursing provided an undated policy titled "Oxygen Therapy and Devices" and indicated that this was the current policy used by the facility. " ...Oxygen devices...(1) nasal cannula ...(e) Change out weekly and as needed ...(f) place in bag when not in use ...." On 12/8/2023 at 9:00 A.M., the Director of Nursing provided an undated policy titled "Oxygen Concentrator" and indicated that this was the current policy used by the facility. " ...daily maintenance (1) Check the water level in the humidity bottle and change the bottle as needed every seven days ...." 3.1-47 (a)(6)		QAPI Audit tool “Oxygen Therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to properly store refrigerated medications in 1 of 3 medication refrigerators that were observed for drug storage (Cottage Unit). Finding includes: An observation of the medication refrigerator on the Cottage Unit was completed on 12/7/2023 at 8:18 A.M. The medication refrigerator's freezer had a heavy built-up of ice that was melting and causing water to accumulate in a red bin containing resident's medications. During an interview, completed on 12/7/2023 at 8:23 A.M., the Director of Nursing indicated there was water dripping onto resident's medications in the refrigerator, and there should not be. On 12/7/2023 at 10:30 A.M., the Director of Nursing provided a policy, with a revision date of 7/21/2022, and titled, "Storage and Expiration Dating of Medications and Biologicals,". The Director Nursing indicated it was the policy currently being used by the facility. The policy indicated, "...This Policy sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and	F 0761	**F761 Label/Storage Drugs and Biologicals** It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Cottage refrigerator was defrosted and cleaned. Resident medications that were affected were disposed of per policy and replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. The DNS/designee will complete a facility wide audit of all medication refrigerators to ensure that all are defrosted and cleaned. **What measures will be put into**	01/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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
	needles...11. Facility should monitor refrigerated storage for evidence of moisture and condensation (humidity) and may consult with the pharmacy regarding medication integrity...." 3.1-25(m)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Medication Storage on or before 1/7/23. The in-service will be conducted by the DNS/designee and will review the facility policy related to Storage of medications and biologicals. The DNS/designee will be responsible for a facility wide weekly medication refrigerator inspection. This will ensure that refrigerated medication storage areas are in proper working order per facility policy and procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/08/2023

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

(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