STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING -- B. WING	01/02/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/02/24 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Emergency Preparedness survey, West Bend Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 157 and had a census of 54 at the time of this survey. Quality Review completed on 01/04/24	E 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. This plan is submitted to meet requirements established by state and federal law. Due to the relative low scope and severity of this survey, the facility is respectfully requesting a desk review in lieu of a post-survey revisit.	
K 0000 Bldg. 01	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). Survey Date: 01/02/24 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in compliance with Requirements for Participation in	K 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. This plan is submitted to meet requirements established by state and federal law. Due to the relative low scope and severity of this survey, the facility is respectfully requesting a desk review in lieu of a post-survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Corrine	Thompson	01/19/2024

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The building is fully protected by a 400 kW diesel powered generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 53 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/04/24			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.			

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	Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms on the office hall with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect approximately 5 staff and an unknown number of residents Findings include: Based on observation during a tour of the facility with Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., the storage room, across from the Director of Nursing' office contained over 50 boxes of supplies, 8 wooden pallets, and was greater than 50 square feet making this a hazardous area. The storage room was not	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All Pallets were removed from storage room. Hinges were ordered and received and placed on 01/16/2024 making said door a self closure to protect the area. 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 other storage areas were assessed for self closure doors and were compliant. No other	01/19/2024

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	protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on Hazardous Areas-Closures on 01/10/2024. The Maintenance Director or designee will inspect all storage room doors on preventative maintenance rounds monthly for compliance. 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: The Executive Director or designee will rounded with the Maintenance Director prior to date of compliance and review the preventative maintenance checks performed by the Maintenance Director monthly. Any results /findings will be reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	
K 0353 SS=E Bldg. 01	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,			

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	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 coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 electrical rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., in the suspended ceiling the electrical room there were two approximately 4 inch holes in two suspended ceiling tiles in the kitchen near the water heater. The holes were close to two sprinkler heads which could delay their activation. Based on interview at the time of observation, the Maintenance Director agreed that there were holes in the ceiling that would have to be filled in. The finding was reviewed with the Maintenance Director during the exit conference.	K 0353	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The noted penetrations around the sprinkler heads in the ceiling tiles were repaired/replaced and sealed with 3M Fire Barrier CP 25WB+. 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 surrounding area to sprinkler heads inspected for penetrations and were compliant. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on Sprinkler System-Maintenance and Testing on 01/10/2024. The Maintenance Director or designee will inspect all All surrounding area to	01/19/2024

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	3.1-19(b)		sprinkler heads inspected for penetrations on preventative maintenance rounds monthly for compliance. 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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and will review the preventative maintenance checks performed by Maintenance Director monthly. Any results /findings will be corrected timely and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger	K 0355	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The noted fire extinguisher was mount securely to a wall. The noted 5 extinguishers were checked for current compliance on	01/19/2024

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	intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observations during a tour of the facility between 12:12:05 p.m. and 2:33 p.m. with the Maintenance Director on 01/02/24, an ABC portable fire extinguisher in the Activities Director's office was sitting on a shelf of a bookcase unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the shelf, unsecured, and would have to be mounted for proper use. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to inspect 5 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers,		01/10/2024. 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 fire extinguishers were inspected for secured mounting and pressure indicator were compliant. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on Portable Fire Extinguishers on 01/10/2024. The Maintenance Director or designee will inspect all fire extinguishers for secured mounting monthly with fire extinguisher inspections ongoing for compliance. A numbered floor map showing all extinguishers in facility was created with a monthly check off audit tool for completion monthly. 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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and review the preventative maintenance checks performed by the Maintenance Director. Any results /findings will be corrected timely and reviewed	

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	cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect approximately 20 staff and residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., the following fire extinguishers were missing monthly inspections: a) The ABC extinguisher next to the chapel was missing monthly inspections for August & December 2023 b) The ABC extinguisher in the Activities Director's office was missing monthly inspections for August & September 2023 c) The ABC extinguisher next to room 210 and across 202 was missing monthly inspections for August 2023 d) The ABC extinguisher near the employee		by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	

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	entrance was missing monthly inspections for August and November 2023. Based on interview at the time of observations, the Maintenance Director stated that he was unaware why the fire extinguishers were missing monthly inspections and he only records monthly inspections on the tags provided. He confirmed that the extinguisher inspections were missing. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas			

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	where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., in the staff smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Cigarette butts were also noted along the lawn and around the nearby generator. Based on interview at the time of observations, the Maintenance Director agreed there was an excessive amount of cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0741	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The smoking area and lawn area around the generator was cleared of all visible cigarette butts. 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: The smoking area and generator area was inspected for visible cigarette butts and for visible placement of the non combustible containers for their disposal and was compliant. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on K741 Smoking Regulations on 01/10/2024 and staff on 01/15/2024 and 01/17/2024. . The Maintenance Director or designee will inspect and correct the facility outdoor premises during preventative maintenance rounds 5x a week for 2 weeks then monthly for compliance.	01/20/2024

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			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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and will review monthly the preventative maintenance checks performed by the Maintenance Director. Any results findings will be corrected timely and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 12 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	K 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The noted fire door was inspected on 01/03/2024 and found compliant. 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: The facility annual inspection for all other fire doors was completed July of 2023 area found in compliance. The noted door was added to the annual inspection in	01/19/2024

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	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 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 approximately 10 residents and staff. Findings include:		TELS. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on K761 Maintenance , Inspection & Testing-Doors on 01/10/2024. The Maintenance Director or designee will inspect the facility doors annually and as needed for compliance. 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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and will review the preventative maintenance checks performed by the Maintenance Director annually. Any results /findings will be corrected timely and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 01 B. WING	01/02/2024

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

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	Based on observation during a tour of the facility with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., the oxygen transfilling/storage room had a fire door with a rating of a 1-1/2 hour rated door. Based on record review between 09:27 a.m and 12:04 p.m., no annual inspection for the oxygen storage/transfilling room was available for review. Based on interview at the time of record review, the Maintenance Director stated he was unsure if a fire door inspection had been done for that specific door. He later confirmed that no documentation could be found stating an annual inspection was completed. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	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) assembles 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			

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	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 2 of 2 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., in the office for the Director of Nursing, a power strip used to power computer equipment, was not secured, and was dangling from the outlet on the wall. Furthermore, a dangling power strip was located in the computer room next to the therapy room which was powering fax machine appliances. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor.	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The noted power strips in the Director of Nursing office and in the computer room were mount to the wall to relieve cord stress and are now compliant. 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: The Maintenance Director inspected all power strips for power strip relief/mounting on 01/11/2024 and found in compliance. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on K920 Electrical Equipment - Power /cords and extension cords on 01/10/2024. The Maintenance Director or designee will inspect rooms facility for usage and are attached to relief cord stress monthly during	01/19/2024

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	This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		preventative maintenance rounds. 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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and review monthly the preventative maintenance checks performed by the Maintenance Director. Any results /findings will be corrected timely and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided	K 0927	What corrective action(s) will be accomplished for those residents found to have been affected by the	01/19/2024

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	with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., the oxygen storage/transfer room near the employee entrance contained large liquid oxygen tanks and small portable oxygen cylinders. There was one vent installed on the ceiling, but the vent did not work when tested. A piece of paper was put up against the fan, it did not stick to the fan and presumed to not be working. Based on interview at the time of observation, the Maintenance Director stated that usually he's able to hear the fan go, however he did not hear it running. He confirmed with the paper that the fan was not working and it would have to get fixed. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)		deficient practice: The Maintenance Director immediately contacted Herman and Goetz to schedule inspection and/ or repair of the exhaust fan in oxygen storage room. Inspected on 01/10/24 and repair completed on 01/12/24. 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: Facility has only one O2 storage room. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on Gas Equipment - Transfilling Cylinders exhaust.... on 01/10/2024. The Maintenance Director or designee will check function during monthly preventative maintenance rounds for compliance. 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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and will review the preventative maintenance checks performed by the Maintenance Director monthly. Any results	

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			/findings will be corrected timely and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	
K 0000 Bldg. 02	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). Survey Date: 01/02/24 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the	K 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. This plan is submitted to meet requirements established by state and federal law. Due to the relative low scope and severity of this survey, the facility is respectfully requesting a desk review in lieu of a post-survey revisit.	

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	corridors and battery operated smoke detectors in all resident rooms. The building is fully protected by a 400 kW diesel powered generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 54 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/04/24			
K 0363 SS=D Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 12 resident room corridor doors in the memory care wing was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents in room 9. Findings include: Based on observation with the Maintenance Director on 01/02/24 between 12:05 p.m. and 2:33 p.m., the corridor door to resident room 9 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director agreed that the door would not latch and would have to be adjusted. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The door on rm 9 was repaired and properly latches. 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 resident room doors were inspected for impediment for latching on 01/17/2024 and were compliant. No other residents were affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on Corridors- Doors on 01/10/2024. The Maintenance Director or designee inspect all	01/19/2024

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			doors monthly for proper door closure during preventative maintenance rounds for compliance. 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: The Executive Director or designee will round with the Maintenance Director prior to date of compliance and will review the preventative maintenance checks performed by the Maintenance Director monthly. Any results /findings will be corrected timely and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	
K 0000 Bldg. 03	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). Survey Date: 01/02/24 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this Life Safety Code survey, West Bend Nursing and Rehabilitation was found not in	K 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. This plan is submitted to meet requirements established by state and federal law. Due to the relative low scope and severity of this survey, the facility is respectfully requesting a desk review in lieu of a post-survey	

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	compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consists of three connected buildings: Building 01, a two story, fully sprinklered building of Type II (222) construction; Building 02, a one story, fully sprinklered building of Type V (000) construction with a partial basement and Building 03, a one story, fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident rooms. The building is fully protected by a 400 kW diesel powered generator. The facility has a capacity of 157 beds dually certified for Medicare and Medicaid and had a census of 54 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/04/24		revisit.	
K 0211 SS=E Bldg. 03	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director 01/02/24 between 12:05 p.m. and 2:33 p.m., the service hall exit corridor connecting the main building and the laundry area contained storge taking almost half of the corridor with. Items included: furniture, trash, a box cart, and two pallets with miscellaneous items on it. Based on an interview at the time of observations, the Maintenance Director agreed there was innapropriate storage in the exit corridor and stated some of it was trash and some was recent deliveries of items. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0211	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All obstructions (furniture, trash pallets etc.) located in exit corridors within the facility were removed. 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 corridors were assessed for any obstructions are were free from obstruction and impediments. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on Means of Egress-Obstructions and Impediments on 01/10/2024. The Maintenance Director or designee will inspect all corridors on preventative maintenance rounds 5x a week for 2 weeks then monthly for any obstructions or impediments for compliance. 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: The Executive Director or designee will round with the Maintenance Director prior to compliance date and check the	01/19/2024

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			preventative maintenance checks performed by the Maintenance Director monthly. Any results /findings will be reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2024	