	MEDICARE & MEDIC		OMB NO. 0938-039				
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155355	B. WING		01/02/2024		
	PROVIDER OR SUPPLIER	L D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
E 0000	REGULATURI UR	LEG DENTI TING IN ORMATION	IAU		DATE		
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	170			
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 in the statement of deficiencies of any violation of regulation. It plan is submitted to meet requirements established by sand federal law. Due to the relative low scope severity of this survey, the fact is respectfully requesting a direview in lieu of a post-survey revisit.	ot s s t forth es, or This state and ility esk		

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

(X6) DATE

TITLE

 Corrine
 Thompson
 01/19/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		r í	JILDING	nstruction 01	(X3) DATE COMPL 01/02/	ETED	
	PROVIDER OR SUPPLIER	D REHABILITATION		4600 W	DDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Medicare/Medicaid. Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This facility consist buildings: Building sprinklered building Building 02, a one s of Type V (000) cor basement and Build sprinklered building The facility has a fir detection in the corr corridors and batter all resident rooms. To by a 400 kW diesel facility has a capaci for Medicare and M 53 at the time of this All areas where resi were sprinklered. A services were sprink Quality Review con	the 2012 edition of the end the 2012 edition of the end the 2012 edition of the end Association (NFPA) 101, SC), Chapter 19, Existing encies and 410 IAC 16.2. Is of three connected 01, a two story, fully gof Type II (222) construction; tory, fully sprinklered building enstruction with a partial ing 03, a one story, fully gof Type V (111) construction. The ealarm system with smoke endors, in spaces open to the goperated smoke detectors in the building is fully protected powered generator. The try of 157 beds dually certified edicaid and had a census of survey. In the survey of the end o					
K 0321 SS=E Bldg. 01	barrier having 1-ho (with 3/4 hour fire automatic fire extil accordance with 8 approved automat option is used, the from other spaces	- Enclosure are protected by a fire our fire resistance rating					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	01	COMPI	LETED
		155355	B. W	ING		01/02	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			/ WASHINGTON AVE		
WEST BI	END NURSING AN	ID REHABILITATION			H BEND, IN 46619		
WEG1 B		is religible to the second		00011	1 2 1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2		,
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Doors shall be se	9					
	_	and permitted to have					
		applied protective plates that					
	do not exceed 48 inches from the bottom of the door.						
		and zone locations of					
	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9						1
	Aroo	Automotio Sprinklar					
	Area	Automatic Sprinkler					
	Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)						
	, -	nance, and Paint Shops					
	-	ooms (exceeding 64					
	gallons)	ooms (exoceding of					
	e. Trash Collectio	n Rooms					
	(exceeding 64 gal						
		orage Rooms/Spaces					
	(over 50 square fe						
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	(2)					
	Based on observation	on and interview, the facility	K 0	321	What corrective action(s) will I	ре	01/19/2024
		f 1 storage rooms on the office			accomplished for those reside	nts	1
		ounts of combustible storage			found to have been affected b	y the	
		square feet was protected as a			deficient practice:		
		is deficient practice could			All Pallets were removed from	1	
		ly 5 staff and an unknown			storage room. Hinges were		
	number of residents	S			ordered and received and pla		
					on 01/16/2024 making said do		
	Findings include:				self closure to protect the area		
					How other residents having th		
		on during a tour of the facility			potential to be affected by the		
	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				same deficient practice will be	:	
					identified and what corrective		
					action(s) will be taken:		
		es, 8 wooden pallets, and was			All other storage areas were		
		are feet making this a			assessed for self closure door		
	hazardous area. The	e storage room was not			and were compliant. No other		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPL	
		155355	B. W	'ING		01/02/	2024
	PROVIDER OR SUPPLIER	D REHABILITATION	•	4600 W	ADDRESS, CITY, STATE, ZIP COD I WASHINGTON AVE I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINEDIS DI ANI DE CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE
	1 ^	dous area because the			residents were affected.		
		room was not self-closing or			What measures will be put into		
	_	Based on interview at the time			place or what systemic chang		
		Maintenance Director agreed			will be made to ensure that the		
	_	ntained large amount of			deficient practice does not rec		
	combustible storage, was larger than 50 square				The Maintenance Director was		
	feet, and the corridor door to the room was not				educated on Hazardous Areas		
	self-closing.				Closures on 01/10/2024. The		
					Maintenance Director or desig		
	_	viewed with the Maintenance			will inspect all storage room d	oors	
	Director during the exit conference. 3.1-19(b)				on preventative maintenance	_	
					rounds monthly for compliance		
	3.1-19(0)				How the corrective action(s) we monitored to ensure the defici		
					practice will not recur, i.e., wh		
					quality assurance program wil		
					put into place:	ı be	
					The Executive Director or		
					designee will rounded with the	.	
					Maintenance Director prior to		
					of compliance and review the	dato	
					preventative maintenance che	cks	
					performed by the Maintenance		
					Director monthly. Any results		
					/findings will be reviewed by the	ne	
					QAPI committee during the		
					monthly meeting as needed.		
					By what date the systemic		
					changes will be completed:		
					Compliance Date = 01/19/202	4	
IV 0050	NEDA 464						
K 0353	NFPA 101	Maintananasaast					
SS=E	1 '	- Maintenance and Testing					
Bldg. 01	1 '	- Maintenance and Testing					
		er and standpipe systems					
		ted, and maintained in					
		IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems. n design, maintenance,					
	1	. assign, mannonano,	1		i .		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155355	B. W	ING		01/02	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEI	₹			/ WASHINGTON AVE		
WEST B	END NURSING AN	D REHABILITATION			I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	sting are maintained in a					
		nd 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		K 0	353	What corrective action(s) will	be	01/19/2024
	failed to maintain the ceiling construction of 1 of 1				accomplished for those reside	ents	
		he ceiling tiles trap hot air and			found to have been affected b	y the	
	-	orinkler and cause the sprinkler			deficient practice:		
		ified temperature. NFPA 13,			The noted penetrations arour		
		11 states the distance between			the sprinkler heads in the ceil	_	1
	_	tor and the ceiling above shall			tiles were repaired/replaced a		
		n the type of sprinkler and the			sealed with 3M Fire Barrier C	Р	
		This deficient practice			25WB+.		
	affects all residents				How other residents having the		
	Eindings 1 1 1				potential to be affected by the		
	Findings include:				same deficient practice will be		1
	Rased on observati	ons during a tour of the facility			identified and what corrective		
		ice Director on 01/02/24			action(s) will be taken: All surrounding area to sprink	der	
		and 2:33 p.m., in the			heads inspected for penetration		
		he electrical room there were			and were compliant. No other		
		4 inch holes in two suspended			residents were affected.		
		ritchen near the water heater.			What measures will be put int	'n	
		se to two sprinkler heads which			place or what systemic chang		
		ctivation. Based on interview at			will be made to ensure that th		
	•	tion, the Maintenance Director			deficient practice does not red		
		ere holes in the ceiling that			The Maintenance Director wa		
	would have to be fi				educated on Sprinkler System		
					Maintenance and Testing on		
	The finding was re-	viewed with the Maintenance			01/10/2024. The Maintenance	9	
	Director during the				Director or designee will inspe	ect	
	1				all All surrounding area to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155355	B. WI	NG		01/02/	/2024
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					/ WASHINGTON AVE		
WEST B	END NURSING AN	ID REHABILITATION	SOUTH BEND, IN 46619		I BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
TAG	3.1-19(b)	R LSC IDENTIFTING INFORMATION	1	TAG	sprinkler heads inspected for		DATE
	0.1 15(0)				penetrations on preventative		
					maintenance rounds monthly	or	
					compliance.		
					How the corrective action(s) w		
					monitored to ensure the defici		
					practice will not recur, i.e., who		
					quality assurance program will put into place:	ı n c	
					The Executive Director or		
					designee will round with the		
					Maintenance Director prior to		
					of compliance and will review		
					preventative maintenance che	cks	
					performed by Maintenance Director monthly. Any results		
					/findings will be corrected time	lv	
					and reviewed by the QAPI	.,	
					committee during the monthly		
					meeting as needed.		
					By what date the systemic		
					changes will be completed:	4	
					Compliance Date = 01/19/202	4	
K 0355	NFPA 101						
SS=E	Portable Fire Exti	nguishers					
Bldg. 01	Portable Fire Exti	_					
		iguishers are selected,					
		ed, and maintained in					
	Portable Fire Exti	NFPA 10, Standard for					
	18.3.5.12, 19.3.5.	•					
		ation and interview, the facility	K 03	355	What corrective action(s) will be	e	01/19/2024
		of 2 portable fire extinguishers in	1. 0.		accomplished for those reside		01/19/2021
		op were installed in			found to have been affected b		
		FPA 10, Standard for Portable			deficient practice:		
	_	2010 Edition. Section 6.1.3.4			The noted fire extinguisher wa	ıs	
	•	extinguishers other than			mount securely to a wall.		
		ners shall be installed using any eans. (1) Securely on a hanger			The noted 5 extinguishers were checked for current compliance		
1	or the following life	cans. (1) securety on a nanger	1		I enecyed for entrent combinance	COH	ĺ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155355	B. W	ING		01/02/	/2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ WASHINGTON AVE		
WEST B	END NI IDSING AN	ID REHABILITATION			BEND, IN 46619		
WESTB	END NORSING AN	ID REHABILITATION		30011	1 BEND, IN 400 19		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tinguishers. (2) In the bracket			01/10/2024.		
		inguisher manufacture. (3) In a			How other residents having th	ie	
		oved for such purpose. (3) In a			potential to be affected by the		
		ess. This deficient practice			same deficient practice will be	;	
	could affect approx	simately 15 residents and staff.			identified and what corrective		
					action(s) will be taken:		
	Findings include:				All fire extinguishers were		
					inspected for secured mountir	ng	
		ons during a tour of the facility			and pressure indicator were		
		p.m. and 2:33 p.m. with the			compliant. No other residents		
	Maintenance Director on 01/02/24, an ABC				were affected.		
	1	uisher in the Activities			What measures will be put int	0	
	Director's office was sitting on a shelf of a				place or what systemic chang	es	
	bookcase unsecured. Based on interview at the				will be made to ensure that the	е	
		, the Maintenance Director			deficient practice does not rec	our:	
		sher was sitting on the shelf,			The Maintenance Director wa	s	
	unsecured, and wo	uld have to be mounted for		educated on Portable Fire			
	proper use.				Extinguishers on 01/10/2024.	. The	
					Maintenance Director or design	jnee	
		ussed with the Maintenance			will inspect all fire extinguishe	rs	
	Director at exit con	ference.			for secured mounting monthly	with	
					fire extinguisher inspections		
	3.1-19(b)				ongoing for compliance.		
					A numbered floor map showir	ıg all	
		ation and interview, the facility			extinguishers in facility was		
		portable fire extinguishers in the			created with a monthly check		
		. NFPA 10, Standard for			audit tool for completion mont	•	
		guishers, Section 7.2.1.2 states			How the corrective action(s) w		
	_	hall be inspected either			monitored to ensure the defici		
	1	ans of an electronic device /			practice will not recur, i.e., wh		
	· ·	um of 30-day intervals. Section			quality assurance program wil	ıl be	
	_	c inspection or electronic			put into place:		
	_	extinguishers shall include a			The Executive Director or		
	check of at least the	_			designee will round with the		
	(1) Location in des				Maintenance Director prior to	date	
		to access or visibility			of compliance and review the	_	
		reading or indicator in the			preventative maintenance che		
	operable range or p				performed by the Maintenance		
		nined by weighing or hefting for			Director. Any results /findings		
	self expelling-type extinguishers,				be corrected timely and review	ved	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í				URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLE	
		155355	B. W	ING		01/02/2	2024
NAME OF F	DROLUDED OD GUIDDI IEE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		4600 W	WASHINGTON AVE		
WEST BI	END NURSING AN	D REHABILITATION		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	~ .	extinguishers, and pump tanks			by the QAPI committee during	the	
	` '	es, wheels, carriage, hose, and			monthly meeting as needed.		
	nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers				By what date the systemic		
		-			changes will be completed:	.	
	using pushto-test pressure indicators.				Compliance Date = 01/19/202	24	
	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						
	_	hly manual inspections are					
		-					
	conducted, the date the manual inspection was performed and the initials of the person						
	performing the inspection shall be recorded.						
		uires where manual inspections					
	_	rds for manual inspections					
		ag or label attached to the fire					
	_	inspection checklist					
		or by an electronic method.					
		aires records shall be kept to					
	_	least the last 12 monthly					
		en performed. This deficient					
	_	et approximately 20 staff and					
	residents.	approximately 20 start and					
	Findings include:						
	Based on observation	on during a tour of the facility					
	with the Maintenan	ce Director on 01/02/24					
		and 2:33 p.m., the following fire					
	extinguishers were	missing monthly inspections:					
	a) The ABC extings	uisher next to the chapel was					
	missing monthly in	spections for August &					
	December 2023						
	b) The ABC exting	uisher in the Activities					
	Director's office wa	s missing monthly inspections					
	for August & Septe	mber 2023					
	c) The ABC extings	uisher next to room 210 and					
	across 202 was mis	sing monthly inspections for					
	August 2023						
	d) The ABC exting	uisher near the employee					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/02/2024		
	PROVIDER OR SUPPLIER	D REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP CO / WASHINGTON AVE I BEND, IN 46619	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	August and November Based on interview the Maintenance Di unaware why the fir monthly inspections inspections on the tathat the extinguished Findings were disconsinuspector at exit confusions. Findings were disconsinuspections were disconsing regulations. Smoking Regulations Smoking Regulations Smoking Regulations Smoking regulations shall include not be provisions: (1) Smoking shall ward, or compartned liquids, combustibuted or stored and location, and such signs that read NC posted with the interprotect of the smoking. (2) In health care of smoking is prohibing prominently placed secondary signs where smoking shall not the smoking shall not shall	at the time of observations, rector stated that he was re extinguishers were missing and he only records monthly ags provided. He confirmed reinspections were missing. Sussed with the Maintenance ference. Ons Ons Ons Ons Ons Ons Ons Ons Ons On				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/02/2024 155355 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0741 What corrective action(s) will be 01/20/2024 failed to ensure 1 of 1 smoking areas were accomplished for those residents maintained by disposing cigarette butts in a metal found to have been affected by the or noncombustible container with self-closing deficient practice: cover devices. This deficient practice could affect The smoking area and lawn area approximately 10 staff and an unknown number of around the generator was cleared residents. of all visible cigarette butts. How other residents having the Findings include: potential to be affected by the same deficient practice will be Based on observation during a tour of the facility identified and what corrective with the Maintenance Director on 01/02/24 action(s) will be taken: between 12:05 p.m. and 2:33 p.m., in the staff The smoking area and generator smoking area there were over 30 cigarette butts area was inspected for visible disposed on the ground in and around the cigarette butts and for visible smoking area. Cigarette butts were also noted placement of the non combustible along the lawn and around the nearby generator. containers for their disposal and Based on interview at the time of observations. was compliant. No other residents the Maintenance Director agreed there was an were affected. excessive amount of cigarette butts on the ground What measures will be put into in the aforementioned locations. place or what systemic changes will be made to ensure that the This finding was reviewed with the Maintenance deficient practice does not recur: Director during the exit conference. The Maintenance Director was educated on K741 Smoking 3.1-19(b) 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

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compliance.

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maintenance rounds 5x a week for 2 weeks then monthly for

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DEPARTMENT CENTERS FOF		ORM APPROVED MB NO. 0938-039				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G 01	(X3) DATE COMP	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIER	D REHABILITATION	460	EET ADDRESS, CITY, STATE, ZIP COD 10 W WASHINGTON AVE UTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROP	N BE PRIATE	(X5) COMPLETION DATE
K 0761 SS=E Bldg. 01	Based on observation interview, the faciling inspection and testing	on, records review, and ty failed to ensure annual ng of 1 of 12 fire door	K 0761	How the corrective action(s monitored to ensure the depractice will not recur, i.e., you quality assurance program put into place: The Executive Director or designee will round with the Maintenance Director prior of compliance and will review monthly the preventative maintenance checks perfor the Maintenance Director. A results findings will be correctimely and reviewed by the committee during the month meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/2 What corrective action(s) waccomplished for those resifound to have been affected.	ficient what will be to date ew med by Any ected QAPI hly	01/19/2024
	19.1.1.4.1.1 commu fire barriers require permitted only in co by approved self-cle (See also Section 8. required to have a f 8.3.4.2 shall be problemed to be problemed for the section of	impleted in accordance of LSC inicating openings in dividing d by 19.1.1.4.1 shall be protected originate fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table frected by approved, listed, semblies and fire window accompanying hardware,		deficient practice: The noted fire door was ins on 01/03/2024 and found compliant. How other residents having potential to be affected by t same deficient practice will identified and what correcting action(s) will be taken: The facility annual inspection	the he be ve	

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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

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all other fire doors was completed

compliance. The noted door was

added to the annual inspection in

July of 2023 area found in

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155355	B. WING		01/02/2024	
NAME OF	NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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		B. WING STREET 4600 V	O1 CADDRESS, CITY, STATE, ZIP COD WWASHINGTON AVE H BEND, IN 46619 PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEPICIENCY) TELS. No other residents we affected. What measures will be put integrate place or what systemic change will be made to ensure that the deficient practice does not recommend.	O1/02/2024 (X5) COMPLETION DATE Pre to ges ne	
	sides to assess the overall condition of door			The Maintenance Director wa		
	assembly. NFPA 80, 5.2.4.2 states as a minimum,			educated on K761 Maintenan		
	the following items			Inspection & Testing-Doors o		
	(1) No open holes or breaks exist in surfaces of either the door or frame.			01/10/2024. The Maintenance		
	(2) Glazing, vision light frames, and glazing beads		Director or designee will inspect			
	are intact and securely fastened in place, if so			the facility doors annually and as needed for compliance.		
	· · · · · · · · · · · · · · · · · · ·			How the corrective action(s) v	ما النب	
	equipped. (3) The door, frame, hinges, hardware, and			monitored to ensure the defic		
		reshold are secured, aligned,		practice will not recur, i.e., wh		
		er with no visible signs of		quality assurance program wi		
	damage.	er with no visible signs of		put into place:		
	(4) No parts are mi	ssing or broken.		The Executive Director or		
		s do not exceed clearances		designee will round with the		
	listed in 4.8.4 and 6			Maintenance Director prior to	date	
		g device is operational; that is,		of compliance and will review		
		apletely closes when operated		preventative maintenance che		
	from the full open j			performed by the Maintenanc		
		is installed, the inactive leaf		Director annually. Any results		
	closes before the ac	etive leaf.		/findings will be corrected time		
	(8) Latching hardw	are operates and secures the		and reviewed by the QAPI		
	door when it is in the	he closed position.		committee during the monthly	,	
	(9) Auxiliary hardv	vare items that interfere or		meeting as needed.		
	prohibit operation a	are not installed on the door or		By what date the systemic		
	frame.			changes will be completed:		
	` '	fications to the door assembly		Compliance Date = 01/19/202	24	
	_	ed that void the label.				
		edge seals, where required, are				
		their presence and integrity.				
	_	ice could affect approximately				
	10 residents and sta	aff.				
	Findings include:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	E SURVEY PLETED 12/2024	
	ROVIDER OR SUPPLIER	D REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP V WASHINGTON AVE I BEND, IN 46619	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 0920 SS=E Bldg. 01	with the Maintenand between 12:05 p.m. transfilling/storage in rating of a 1-1/2 hor review between 09:2 annual inspection for storage/transfilling in Based on interview the Maintenance Dina fire door inspection specific door. He lat documentation could inspection was compared to be specific door. He lat documentation could inspection was compared to be specific door. He lat documentation could inspection was compared to be specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documentation could inspection was compared to specific door. He lat documenta	at the time of record review, rector stated he was unsure if in had been done for that the confirmed that no id be found stating an annual pleted. See with the Maintenance ference. The power Cords and the power care vicinity are only into of movable in delectrical equipment.				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	· /	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155355	B. WI	ING		01/02/	/2024
	PROVIDER OR SUPPLIEF	REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	used with general cords are not use wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 9 (NFPA 70), 590.3 Based on observatifialed to ensure 2 o properly and used i Section 10.2.4.2 state cords meeting their through 10.2.4.2.3 states the 10.2.3. Section 10.2.4 state cord to the appliance either pull, twist, or internal connection affect approximated number of residents. Findings include: Based on observation birector on 01/02/2 p.m., in the office of power strip used to was not secured, and on the wall. Further was located in the composer cord causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dis was dangling, not significant to the second causing Based on interview the Maintenance Dispansed to the second causing Based on interview the Maintenance Dispansed causing Based causing Ba	precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. 9), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility f 2 flexible cords were installed n a safe manor. NFPA 99, ttes adapters and extension equirements of 10.2.4.2.1 shall be permitted. Section e cabling shall comply with 2.3.5.1 states cord strain relief t the attachment of the power se so that mechanical stress, r bend, is not transmitted to s. This deficient practice could by 4 staff and an unknown	K 0	TAG	What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice: The noted power strips in the Director of Nursing office and the computer room were mouthe wall to relieve cord stress 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 resident were affected. What measures will be put intended to ensure that the deficient practice does not recompliant to the same deficient practice does not recompliant. The Maintenance Director was educated on K920 Electrical Equipment - Power /cords and extension cords on 01/10/202 The Maintenance Director or designee will inspect rooms facility for usage and are attact to relief cord stress monthly directive.	oe ents y the in unt to and le ents o es e cur: s d 24.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPLETED	
155355		B. WIN	G		01/02/	/2024	
	PROVIDER OR SUPPLIEI	R D REHABILITATION		4600 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	DROVIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	eviewed with the Maintenance			preventative maintenance rou	ınds.	
	Director during the	exit conference.			How the corrective action(s) w		
	2.1.10(1.)				monitored to ensure the deficie		
	3.1-19(b)				practice will not recur, i.e., who		
					quality assurance program will put into place:	be	
					The Executive Director or		
					designee will round with the		
					Maintenance Director prior to	date	
					of compliance and review mor	ıthly	
					the preventative maintenance		
					checks performed by the		
					Maintenance Director. Any		
					results /findings will be correct timely and reviewed by the QA		
					committee during the monthly	VL I	
					meeting as needed.		
					By what date the systemic		
					changes will be completed:		
					Compliance Date = 01/19/202	4	
14 0007	NEDA 101						
K 0927 SS=E	NFPA 101	Transfilling Culindara					
Bldg. 01		Transfilling Cylinders Transfilling Cylinders					
Diag. 01		gen from one cylinder to					
		ordance with CGA P-2.5,					
		h Pressure Gaseous					
	Oxygen Used for	Respiration. Transfilling of					
		cylinder to another is					
		ent care rooms. Transfilling					
		ontainers or to portable					
		0 psi comply with conditions (NFPA 99). Transfilling to					
		tainers or to portable					
		50 psi comply with					
		11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 9	•					
		on and interview, the facility	K 092	27	What corrective action(s) will b		01/19/2024
		f 1 oxygen storage room where			accomplished for those reside		
	oxygen transferring	g takes place, was provided			found to have been affected by	y the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETE			ETED
155355		B. W	ING		01/02/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			/ WASHINGTON AVE		
WEST BI	END NURSING AN	ID REHABILITATION		SOUTH	I BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ring mechanical ventilation.			deficient practice:		
		tion, 11.5.2.3.1 (2) requires			The Maintenance Director		
		rooms to be mechanically			immediately contacted Herma		
		9.3.7.5.3.1 requires mechanical			and Goetz to schedule inspec		
		n a negative pressure in the			and/ or repair of the exhaust	fan	
		7. This deficient practice could			in oxygen storage room.		
	affect approximate	ly 10 residents and staff.			Inspected on 01/10/24 and re	pair	
	F				completed on 01/12/24.		
	Findings include:				How other residents having the		
					potential to be affected by the		
		on during a tour of the facility			same deficient practice will be		
		nce Director on 01/02/24			identified and what corrective		
		a. and 2:33 p.m., the oxygen			action(s) will be taken:		
	_	om near the employee entrance			Facility has only one O2 stora	-	
		uid oxygen tanks and small			room. No other residents we	re	
		rlinders. There was one vent			affected.		
		ling, but the vent did not work			What measures will be put in		
	_	ce of paper was put up against			place or what systemic chang		
		tick to the fan and presumed to			will be made to ensure that th		
	_	ased on interview at the time of			deficient practice does not re-		
		aintenance Director stated that			The Maintenance Director wa		
	1	hear the fan go, however he			educated on Gas Equipment		
		ning. He confirmed with the			Transfilling Cylinders exhaust		
		vas not working and it would			on 01/10/2024. The Maintena		
	have to get fixed.				Director or designee will chec	K	
					function during monthly		
		cussed with the Maintenance			preventative maintenance rou	ınds	
	Director at exit cor	nterence.			for compliance.		
	2.1.10/15				How the corrective action(s)		
	3.1-19(b)				monitored to ensure the defic		
					practice will not recur, i.e., wh		
					quality assurance program wi	II be	
					put into place:		
					The Executive Director or		
					designee will round with the		
					Maintenance Director prior to		
					of compliance and will review		
					preventative maintenance che		
					performed by the Maintenand	е	
				Director monthly. Any results			

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155355	B. WING			01/02/2024	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
WEST DE	TAID AILIDOING AND	D DELIADILITATION			WASHINGTON AVE		
WEST BE	IND NURSING AND	D REHABILITATION		30016	I BEND, IN 46619		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					/findings will be corrected time	ly	
					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	4	
K 0000							
D							
Bldg. 02	A T 10 G G . G . 1	D			<u> </u>	_	į
	-	Recertification and State	K 0	000	The creation and submission o		
		ras conducted by the Indiana			this plan of correction does no		
	•	th in accordance with 42 CFR			constitute an admission by this		
	483.90(a).				provider of any conclusion set		
	G D 4 01/02	1/24		in the statement of defic		-	
	Survey Date: 01/02	2/24			of any violation of regulation.	nis	
	E:1:4 N1 0	00246			plan is submitted to meet		
	Facility Number: 0 Provider Number: 1				requirements established by s	iaie	
	AIM Number: 1002				and federal law.		
	Alivi Nullibel. 1002	2/3420			Due to the relative low scope a		
	At this Life Sofety	Code survey, West Bend			severity of this survey, the faci is respectfully requesting a de	-	
	-	ilitation was found not in			review in lieu of a post-survey	SSK	
	-	equirements for Participation in			revisit.		
	•	, 42 CFR Subpart 483.90(a),			Tevisit.		
		re and the 2012 edition of the					
		etion Association (NFPA) 101,					
		LSC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
	r						
	This facility consists	s of three connected					
	•	01, a two story, fully					
		g of Type II (222) construction;					
		story, fully sprinklered building					
	•	nstruction with a partial					
		ling 03, a one story, fully					
		g of Type V (111) construction.					
		re alarm system with smoke					
	•	ridors, in spaces open to the					
			1				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155355		l í	UILDING	onstruction 02	(X3) DATE COMPL 01/02/	ETED		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
K 0363 SS=D Bldg. 02	corridors and batter all resident rooms. It by a 400 kW diesel facility has a capacity for Medicare and M 54 at the time of this All areas where resimere sprinklered. A services were sprinklered corridor - Doors Corridor - Doors Doors protecting of than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary services.	y operated smoke detectors in The building is fully protected powered generator. The ty of 157 beds dually certified dedicaid and had a census of s survey. dents have customary access ll areas providing facility clered. Impleted on 01/04/24 Corridor openings in other osures of vertical openings, as areas resist the passage made of 1 3/4 inch wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors and flammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain		TAG	DEFICIENCY		DATE	
	covering is not exc doors complying w if provided with a c the door closed wh applied. There is closing of the door	n bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the res. Hold open devices that door is pushed or pulled are						
	permitted. Nonrate	ed protective plates of						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 01/02/2024 155355 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. 01/19/2024 Based on observation and interview, the facility K 0363 What corrective action(s) will be failed to ensure 1 of 12 resident room corridor accomplished for those residents doors in the memory care wing was provided with found to have been affected by the a means suitable for keeping the door closed, had deficient practice: no impediment to closing, latching and would The door on rm 9 was repaired and resist the passage of smoke. This deficient properly latches. practice could affect approximately 2 residents in How other residents having the room 9. potential to be affected by the same deficient practice will be Findings include: identified and what corrective action(s) will be taken: Based on observation with the Maintenance All resident room doors were Director on 01/02/24 between 12:05 p.m. and 2:33 inspected for impediment for p.m., the corridor door to resident room 9 did not latching on 01/17/2024 and were compliant. No other residents

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)

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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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		A. BUILDING B. WING	02	COMPLETED 01/02/2024			
	PROVIDER OR SUPPLIER END NURSING ANI) REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE		
				doors monthly for proper door closure during preventative maintenance rounds for compliance. How the corrective action(s) w monitored to ensure the deficie practice will not recur, i.e., what quality assurance program will put into place: The Executive Director or designee will round with the Maintenance Director prior to of compliance and will review to preventative maintenance che performed by the Maintenance Director monthly. Any results /findings will be corrected time and reviewed by the QAPI committee during the monthly meeting as needed. By what date the systemic changes will be completed: Compliance Date = 01/19/202	ill be ent at l be date the cks		
K 0000							
Bldg. 03	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/02 Facility Number: 01 Provider Number: 1 AIM Number: 1002 At this Life Safety 0	00246 55355	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. It plan is submitted to meet requirements established by stand federal law. Due to the relative low scope as severity of this survey, the facilis respectfully requesting a direview in lieu of a post-survey	t s forth s, or This tate and lity esk		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/02/2024		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD W WASHINGTON AVE	-
WEST BI	END NURSING ANI	D REHABILITATION		H BEND, IN 46619	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE COIVIL EL LOIV
TAG		equirements for Participation in	TAG	revisit.	DATE
		, 42 CFR Subpart 483.90(a),		TO VIOIL.	
		re and the 2012 edition of the			
		ction Association (NFPA) 101,			
		SC), Chapter 19, Existing			
	Health Care Occupa	ancies and 410 IAC 16.2.			
	This facility consist	s of three connected			
	buildings: Building	01, a two story, fully			
		g of Type II (222) construction;			
	1	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.				
		re alarm system with smoke			
		ridors, in spaces open to the			
		y operated smoke detectors in			
		The building is fully protected			
	_	powered generator. The			
		ty of 157 beds dually certified			
		ledicaid and had a census of			
	54 at the time of thi	s survey.			
	All areas where resi	dents have customary access			
		ll areas providing facility			
	services were sprink	clered.			
	Quality Review con	npleted on 01/04/24			
K 0211	NFPA 101				
SS=E	Means of Egress -	- General			
Bldg. 03	Means of Egress -				
	Aisles, passagewa	-			
	_	cations, and accesses are			
		n Chapter 7, and the means			
	all obstructions to	uously maintained free of			
		s modified by 18/19.2.2			
	through 18/19.2.1	-			
	18.2.1, 19.2.1, 7.1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B				ETED	
155355		B. WING 01/02/2024				/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			WASHINGTON AVE		
WEST BE	END NURSING AN	D REHABILITATION			H BEND, IN 46619		
					1		Т
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		on and interview, the facility	K 0	211	What corrective action(s) will I		01/19/2024
		f 6 means of egress were			accomplished for those reside		
	-	ained free of all obstructions			found to have been affected b	y the	
	-	full instant use in the case of			deficient practice:		
	_	ency. This deficient practice			All obstructions (furniture, tras	h	
		imately 5 staff and an unknown			pallets etc.) located in exit		
	number of residents	3.			corridors within the facility wer	e	
	E. 1 1 1				removed.		
	Findings include:				How other residents having th		
	D1 1	stica decine steem Cd			potential to be affected by the		
		ation during a tour of the			same deficient practice will be	!	
	-	intenance Director 01/02/24			identified and what corrective		
	•	and 2:33 p.m., the service hall			action(s) will be taken:		
		eting the main building and the	All corridors were assessed for				
	-	ned storge taking almost half			any obstructions are were free)	
		. Items included: furniture,			from obstruction and		
	trash, a box cart, an	-			impediments.		
		s on it. Based on an interview			What measures will be put into		
		vations, the Maintenance			place or what systemic chang		
		re was innapropriate storage in d stated some of it was trash			will be made to ensure that the		
		a stated some of it was trash at deliveries of items.			deficient practice does not rec		
	and some was recen	it deriveries of items.			The Maintenance Director was		
	The findings were	eviewed with the Maintenance			educated on Means of Egress		
	-				Obstructions and Impediment		
	Director during the	ean comerence.			01/10/2024. The Maintenance		
	3 1 10(b)				Director or designee will inspe	:Ul	
	3.1-19(b)				all corridors on preventative maintenance rounds 5x a wee	.lr	
					for 2 weeks then monthly for a		
					obstructions or impediments for	•	
					compliance.	Ji	
					How the corrective action(s) w	ill he	
					monitored to ensure the defici		
					practice will not recur, i.e., wh		
					quality assurance program wil		
					put into place:	. 50	
					The Executive Director or		
					designee will round with the		
					Maintenance Director prior to		
					compliance date and check th	6	
					Toomphanoe date and check th	U	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	` ′	ILDING	ONSTRUCTION 03	(X3) DATE COMPL 01/02 /	ETED
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION					DATE
					preventative maintenance che 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 = 01/19/202	e ne	

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