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

PRINTED: 02/26/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03		(X3) DATE SURVEY COMPLETED		
		155355	B. WING			R 02/22/2024		
NAME OF PROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 02/	LLILVL	
				4600	W WASHINGTON AVE			
WEST BEND NURSING AND REHABILITATION				SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS	;	{K 0	00}				
	Code Recertification conducted on 01/02/2 Indiana Department of CFR Subpart 483.90 Survey Date: 02/22/2 Facility Number: 000 Provider Number: 15 AIM Number: 10027 At this Life Safety Co and Rehabilitation was Requirements for Pal Medicare/Medicaid, 4 Life Safety from Fire National Fire Protecti Life Safety Code (LS Health Care Occupant This facility consists of Type II (222) consistory, fully sprinklered construction with a part of the construction with a part of the construction of the construction of the construction is fully powered generator. In 157 beds dually certification of the conduction of the construction of	246 5355 5420 de PSR, West Bend Nursing as found in compliance with rticipation in 122 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing ncies and 410 IAC 16.2. of three connected buildings: bry, fully sprinklered building truction; Building 02, a one dibuilding of Type V (000) artial basement and Building sprinklered building of Type. The facility has a fire alarm etection in the corridors, in orridors and battery ectors in all resident rooms. rotected by a 400 kW diesel. The facility has a capacity of						
	this survey.							
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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.

Facility ID: 000246

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155355		B. WING			R 02/22/2024		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			46	REET ADDRESS, CITY, STATE, ZIP CODE 500 W WASHINGTON AVE OUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}		ents have customary access areas providing facility ered.	{K 0	00}			
{K 000}	INITIAL COMMENTS		{K 0	00}			
	Code Recertification a conducted on 01/02/2 Indiana Department of CFR Subpart 483.90(Survey Date: 02/22/2 Facility Number: 000 Provider Number: 156 AIM Number: 100275 At this Life Safety Coand Rehabilitation was Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSG Health Care Occupar	246 5355 5420 de PSR, West Bend Nursing is found in compliance with ticipation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing icies and 410 IAC 16.2.					
	Building 01, a two sto of Type II (222) const story, fully sprinklered construction with a pa 03, a one story, fully s V (111) construction. system with smoke do spaces open to the co	of three connected buildings: ry, fully sprinklered building ruction; Building 02, a one I building of Type V (000) artial basement and Building sprinklered building of Type The facility has a fire alarm etection in the corridors, in burridors and battery ctors in all resident rooms.					

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155355		155355	B. WING			R	
NAME OF PROVIDER OR SUPPLIER		5		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	22/2024	
WEST BEND NURSING AND REHABILITATION					4600 W WASHINGTON AVE SOUTH BEND, IN 46619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE	
{K 000}	powered generator. T 157 beds dually certif Medicaid and had a c this survey.	rotected by a 400 kW diesel he facility has a capacity of ied for Medicare and ensus of 56 at the time of ents have customary access	{K C	000	}		
{K 000}	were sprinklered. All a services were sprinkle Quality Review compl INITIAL COMMENTS	ered. leted on 02/23/24	{K 0	000]	}		
	Code Recertification a conducted on 01/02/2	t (PSR) to the Life Safety and State Licensure Survey 4 was conducted by the f Health in accordance 42 a).					
	Survey Date: 02/22/2	24					
	Facility Number: 000 Provider Number: 155 AIM Number: 100275	5355					
	and Rehabilitation wa Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protection Life Safety Code (LSC	de PSR, West Bend Nursing s found in compliance with ticipation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing icies and 410 IAC 16.2.					
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	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	02/22/2024	
WEST BEND NURSING AND REHABILITATION				SOUTH BEND, IN 46619			
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{K 000}	03, a one story, fully s V (111) construction. system with smoke do spaces open to the co operated smoke dete The building is fully powered generator. T 157 beds dually certif Medicaid and had a co this survey.	artial basement and Building sprinklered building of Type The facility has a fire alarm etection in the corridors, in orridors and battery ctors in all resident rooms. Totected by a 400 kW diesel the facility has a capacity of fied for Medicare and tensus of 56 at the time of tents have customary access areas providing facility ered.	{K 0	000}			