	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	-	
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER		VESTERN AVENUE H BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
0000						
3ldg	conducted by the I in accordance with Survey Date: 05/1 Facility Number: Provider Number: AIM Number: 20 At this Emergency Briarcliff Health at found not in comp Preparedness Requ Medicaid Participa 42 CFR 483.73	0/22 013420 155831 1293620 Preparedness survey, nd Rehabilitation Center was liance with Emergency nirements for Medicare and tting Providers and Suppliers, 1 certified beds. At the time	E 0000	K000 Attached is the plan of correct for the Life Safety Code with Emergency Preparedness K0 Survey conducted at Briarclift Health & Rehabilitation May 2022. The facility is respectfur requesting desk review regard this survey.	000 ff 10, µlly	
0004 SS=C 3ldg	403.748(a), 416.9 441.184(a), 482. 483.73(a), 484.10 485.68(a), 485.72 486.360(a), 491. Develop EP Plan Annually §403.748(a), §41 §441.184(a), §46 §483.73(a), §483 §485.68(a), §485	mpleted on 05/17/22 54(a), 418.113(a), 15(a), 483.475(a), 02(a), 485.625(a), 27(a), 485.920(a), 12(a), 494.62(a) , Review and Update 6.54(a), §418.113(a), 0.84(a), §482.15(a), 4.475(a), §484.102(a), 6.625(a), §485.727(a), 6.360(a), §491.12(a),				

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Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

	NT OF DEFICIENCIES		SERVICES           PROVIDER/SUPPLIER/CLIA         X2) MULTIPLE CONSTRUCTION			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155831	B. WING		05/10	/2022
NAME OF	PROVIDER OR SUPPLIEI	2		ADDRESS, CITY, STATE, ZIP CODE	_	
				VESTERN AVENUE		
BRIARC		HABILITATION CENTER	50011	H BEND, IN 46619		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF		COMPLET
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		d local emergency				
		uirements. The [facility]				
		ablish and maintain a				
		mergency preparedness				
		ts the requirements of this				
		rgency preparedness				
	the following elem	lude, but not be limited to,				
		lents.				
	(a) Emergency Pl	an. The [facility] must				
		tain an emergency				
		n that must be [reviewed],				
		ast every 2 years. The plan				
	must do all of the					
		-				
	* [For hospitals at	§482.15 and CAHs at				
	§485.625(a):] Em	ergency Plan. The [hospital				
		nply with all applicable				
		nd local emergency				
		uirements. The [hospital or				
	CAH] must develo	-				
		mergency preparedness				
		ts the requirements of this				
	section, utilizing a	n all-hazards approach.				
	* [For LTC Faciliti	es at §483.73(a):]				
		The LTC facility must				
		tain an emergency				
		n that must be reviewed,				
	and updated at le					
	1	5				
	* [For ESRD Faci	lities at §494.62(a):]				
	Emergency Plan.	The ESRD facility must				
	develop and main	tain an emergency				
	preparedness pla	n that must be [evaluated],				
	and updated at le	ast every 2 years.				
	Based on record rec	view and interview, the	E 0004	E004		06/17/2
		view and update the	E 0004	1. The facility has a		00/1//2
		new and update the		1. 110 aomity nas a		1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O Emergency Prepar annually in accord This deficient prac	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) redness Plan (EPP) at least ance with 42 CFR 483.73(a). trice could affect all	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROP DEFICIENCY) written/documented Emerge Preparedness program that been implemented and will	RIATE COMPLETION DATE DATE has be	
Ξ 0006 SS=C Bldg	Administrator in T Maintenance, Mai Director of Mainte on 05/10/22 betwee the EEP lacked a d be found to show the updated within the interview during r Director stated the but during the surve provided indication the last year. This finding was a Administrator in T Maintenance, Mai Director of Mainte the time of discove conference with A Director of Mainte Director of Mainte Director of Mainte and Corporate Rep p.m. 403.748(a)(1)-(2) 482.15(a)(1)-(2), 483.73(a)(1)-(2),	review and interview with the raining, Director of Intenance Assistant and mance from another facility ten 9:45 a.m. and 12:15 p.m., rover page, and no date could the EPP was reviewed and e last year. Based on an ecords review, the Maintenance EEP was reviewed recently vey no documentation was g the EPP was updated within cknowledged by the raining, Director of intenance Assistant and mance from another facility at ery and again at the exit dministrator in Training, mance, Maintenance Assistant, mance from another facility presentative present at 4:15 ), 416.54(a)(1)-(2), (483.475(a)(1)-(2), (483.475(a)(1)-(2), (485.68(a)(1)-(2), ), 485.68(a)(1)-(2), ), 485.920(a)(1)-(2),		reviewed and updated annual assure compliance. 2. The facility has identified residents as having the pote be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed each nursing unit, all staff h been educated on the plan. Manager will provide trainin new hires and will present a quarterly review of the plan staff at the mandatory inser An annual review and updat be scheduled to assure compliance. 4. The Risk Manager/design report education dates to ne hires and all staff to the QAI committee to assure that fact remains in compliance.	all ential to ss on as Risk g to to all vice. te will nee will ew Pl	

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TERSTO	R MEDICARE & MEDIC						
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. I	BUILDING		COM	<b>IPLETED</b>
		155831	В. V	B. WING			10/2022
				STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIEI	R		5024 W	/ESTERN AVENUE		
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER		SOUTH BEND, IN 46619			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX	(EACH DEFICIEN	VCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Plan Based on Al	l Hazards Risk Assessment					
	§403.748(a)(1)-(2	2), §416.54(a)(1)-(2),					
	§418.113(a)(1)-(2	2), §441.184(a)(1)-(2),					
	§460.84(a)(1)-(2)	, §482.15(a)(1)-(2),					
	§483.73(a)(1)-(2),	, §483.475(a)(1)-(2),					
	§484.102(a)(1)-(2	2), §485.68(a)(1)-(2),					
		2), §485.727(a)(1)-(2),					
	§485.920(a)(1)-(2	2), §486.360(a)(1)-(2),					
	§491.12(a)(1)-(2)	, §494.62(a)(1)-(2)					
	[(a) Emergency P	lan. The [facility] must					
		itain an emergency					
		n that must be reviewed,					
		ast every 2 years. The plan					
	must do the follow						
	(1) Be based on a	and include a documented,					
	facility-based and	community-based risk					
	assessment, utiliz	zing an all-hazards					
	approach.*						
	(2) Include strateg	gies for addressing					
	emergency event	s identified by the risk					
	assessment.						
	* [For Hospices a	t §418.113(a):] Emergency					
		e must develop and					
		gency preparedness plan					
		ewed, and updated at least					
		e plan must do the					
	following:						
	(1) Be based on a	and include a documented,					
	facility-based and	community-based risk					
		zing an all-hazards					
	approach.						
	(2) Include strateg	gies for addressing					
		s identified by the risk					
	assessment, inclu	uding the management of					
		s of power failures, natural					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE ( A. BUILDING B. WING	<u> </u>	(X3) DATE SURVEY COMPLETED 05/10/2022	
	NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER			TADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE TH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	*[For LTC facilitie Emergency Plan. develop and main preparedness pla and updated at le do the following: (1) Be based on a facility-based and assessment, utiliz approach, includii (2) Include strateg emergency event assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency pre be reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includii (2) Include strateg emergency event assessment. Based on record re facility failed to ma preparedness plan t includes a documer community-based re all-hazards approact and (2) included strateg emergency events in assessment in according to the second assessment in according to the second assessment in according to the second temergency events in assessment in according to the second assessment i	's ability to provide care. s at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. The plan must and include a documented, community-based risk ting an all-hazards ng missing residents. gies for addressing s identified by the risk §483.475(a):] Emergency must develop and maintain eparedness plan that must updated at least every 2 nust do the following: and include a documented, community-based risk ting an all-hazards ng missing clients. gies for addressing s identified by the risk wiew and interview, the tintain an emergency hat was (1) based on and nted, facility-based and isk assessment, utilizing an th, including missing residents rategies for addressing dentified by the risk rategies for addressing dentified by the risk	E 0006	E006 1. The facility has a written/documented Emergency Preparedness program that is based on a risk-assessment usin an all-hazards approach specific to the geographic location of the facility and is in compliance with the plan. 2. The facility has identified all residents as having the potential		

	NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY COMPLETED		
		155831	B. WING		05/10/2022	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	deficient practice	could affect all occupants.		be affected by this deficient practice.		
	Findings include:			3. Emergency Preparedness manuals have been placed or	h	
	Administrator in T Maintenance, Mai Director of Mainte on 05/10/22 betwee no documentation Long Term Care F included a docume community-based all-hazards approa and included strate events identified b This finding was a Administrator in T Maintenance, Mai Director of Mainte the time of discovy conference with A Director of Mainte an additional Director	review and interview with the Graining, Director of Intenance Assistant and enance from another facility een 9:45 a.m. and 12:15 p.m., was available to show that the Gracility was based on and ented facility-based and risk assessment, utilizing an ch, including missing residents egies for addressing emergency by the risk assessment. Incknowledged by the Graining, Director of Intenance Assistant and enance from another facility at ery and again at the exit dministrator in Training, enance, Maintenance Assistant, ctor of Maintenance from d Corporate Representative		<ul> <li>each nursing unit, all staff has been educated on the plan. R Manager will provide training new hires and will present a quarterly review of the plan to staff</li> <li>4. The Risk Manager/designer report new hire and staff</li> <li>education dates to the QAPI committee to assure that facil remains in compliance.</li> </ul>	iisk to all e will	
E 0013 SS=C Bldg	403.748(b), 416. 441.184(b), 482. 483.73(b), 484.1 485.68(b), 485.7 486.360(b), 491. Development of §403.748(b), §41 §441.184(b), §46 §483.73(b), §483 §485.68(b), §485	54(b), 418.113(b), 15(b), 483.475(b), 02(b), 485.625(b), 27(b), 485.920(b),				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

Page 6 of 86 If continuation sheet

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2022			
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETIC DATE	
	develop and imp preparedness por based on the em paragraph (a) of assessment at pa- section, and the paragraph (c) of and procedures in updated at least *[For LTC facilities and procedures. develop and imp preparedness por based on the em paragraph (a) of assessment at pa- section, and the paragraph (c) of and procedures. *Additional Requind ESRD Facilities: *[For PACE at §4 procedures. The develop and imp preparedness por based on the em paragraph (a) of assessment at pa- section, and the paragraph (c) of and procedures in based on the em paragraph (a) of assessment at pa- section, and the paragraph (c) of and procedures in of medical and n including, but not	aragraph (a)(1) of this communication plan at this section. The policies must be reviewed and every 2 years. As at §483.73(b):] Policies The LTC facility must lement emergency licies and procedures, ergency plan set forth in this section, risk aragraph (a)(1) of this communication plan at this section. The policies must be reviewed and annually. irements for PACE and PACE organization must lement emergency licies and procedures, ergency plan set forth in						

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155831	B. WING		05/10/2022	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	2R		VESTERN AVENUE		
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER		H BEND, IN 46619		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		(X5)	
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETIO	
TAG	Ϋ́,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE	
		d natural disasters likely to				
	•	th or safety of the				
		f, or the public. The policies				
		nust be reviewed and				
	updated at least					
	*[For ESRD Faci	lities at §494.62(b):]				
		edures. The dialysis				
		elop and implement				
		aredness policies and				
	• • • •	ed on the emergency plan				
		raph (a) of this section, risk				
		aragraph (a)(1) of this				
		communication plan at				
		this section. The policies				
		must be reviewed and				
		every 2 years. These				
		ude, but are not limited to,				
	fire, equipment o					
		rgencies, water supply				
		natural disasters likely to				
		ty's geographic area.				
			E 0012	E013	06/17/202	
		eview and interview, the	E 0013	1. The facility has an Emergen	06/17/202	
		view and update the edness Plan's (EPP) Policies		Preparedness program. The	<sup>Uy</sup>	
	e	. ,				
		least annually in accordance		facility has policies and	d	
		73(a). This deficient practice		procedures that were develope	iu III	
	could affect all oco	cupants.		based on the facility and		
	Eindigen in 1 1			community-based		
	Findings include:			risk-assessment, and on the communication plan utilizing ar		
	Based on records	eview and interview with the		all-hazards approach that is	'	
		raining, Director of		specific to the geographic locat	ion	
		ntenance Assistant and		of the facility.		
		enance from another facility		2. The facility has identified all		
		-		residents as having the potential	alto	
		en 9:45 a.m. and 12:15 p.m.,			aitu	
		cover page, and no date could		be affected by this deficient		
		the EEP's Policies and		practice.		
		viewed and updated within the an interview during records		3. Emergency Preparedness manuals have been placed on		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

If continuation sheet

Page 8 of 86

Maintenance, Maintenance Assistant and

the time of discovery and again at the exit

conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, Director of Maintenance from another facility and Corporate Representative present at 4:15

Director of Maintenance from another facility at

403.748(b)(2), 416.54(b)(1), 418.113(b)(6)

483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and

§403.748(b)(2), §416.54(b)(1), §418.113(b) (6)(ii) and (v), §441.184(b)(2), §460.84(b)

§483.475(b)(2), §485.625(b)(2), §485.920(b)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in

(2), §482.15(b)(2), §483.73(b)(2),

(1), §486.360(b)(1), §494.62(b)(1).

paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies

(ii) and (v), 441.184(b)(2), 482.15(b)(2),

(X4) ID

PREFIX

TAG

p.m.

Patients

E 0018

SS=C

Bldg. --

**CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 05/10/2022 155831 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 **BRIARCLIFF HEALTH & REHABILITATION CENTER** SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) review, the Maintenance Director stated the EEP each nursing unit; all staff has was reviewed recently but during the survey no been educated on the plan. Risk Manager will provide training to documentation was provided indicating the EEP's new hires and will present a Policies and Procedures was updated within the quarterly review of the plan to all last year. staff This finding was acknowledged by the 4. The Risk Manager/designee will Administrator in Training, Director of report on her education to new

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVO021

hires and all staff to the QAPI

remains in compliance

committee to assure that facility

Page 9 of 86

Facility ID: 013420

If continuation sheet

AND PLAN (	DF CORRECTION ROVIDER OR SUPPLIER IFF HEALTH & RE SUMMARY S' (EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	HABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) iust address the following:] m to track the location of sheltered patients in the ing an emergency. If	î î	JILDING ING STREET A 5024 W	ADDRESS, CITY, STATE, ZIP CODE ESTERN AVENUE BEND, IN 46619 PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	BE	LETED
NAME OF P BRIARCL (X4) ID PREFIX	ROVIDER OR SUPPLIER IFF HEALTH & RE SUMMARY S' (EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	155831 HABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Furst address the following:] In to track the location of sheltered patients in the ing an emergency. If		ING STREET A 5024 W SOUTH ID PREFIX	ESTERN AVENUE BEND, IN 46619 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	05/10	(X5) COMPLET
BRIARCL (X4) ID PREFIX	IFF HEALTH & RE SUMMARY S' (EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	HABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Pust address the following:] Im to track the location of sheltered patients in the ing an emergency. If	B. W	STREET A 5024 W SOUTH ID PREFIX	ESTERN AVENUE BEND, IN 46619 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	ON BE	(X5) COMPLET
BRIARCL (X4) ID PREFIX	IFF HEALTH & RE SUMMARY S' (EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	HABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) iust address the following:] m to track the location of sheltered patients in the ing an emergency. If		5024 W SOUTH ID PREFIX	ESTERN AVENUE BEND, IN 46619 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLET
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) inust address the following:] Im to track the location of sheltered patients in the ing an emergency. If		SOUTH ID PREFIX	BEND, IN 46619 PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO	BE	COMPLET
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) inust address the following:] Im to track the location of sheltered patients in the ing an emergency. If		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC	BE	COMPLET
PREFIX	(EACH DEFICIEN REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) uust address the following:] m to track the location of sheltered patients in the ing an emergency. If		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLET
	REGULATORY OR and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	LSC IDENTIFYING INFORMATION) uust address the following:] m to track the location of sheltered patients in the ing an emergency. If			CROSS-REFERENCED TO THE APPRC		
TAG	and procedures m [(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	must address the following:] m to track the location of sheltered patients in the ing an emergency. If		TAG	DEFICIENCY)		DATE
	[(2) or (1)] A syste on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	m to track the location of sheltered patients in the ing an emergency. If					
	on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	sheltered patients in the ing an emergency. If					
	on-duty staff and s [facility's] care dur on-duty staff and s relocated during th	sheltered patients in the ing an emergency. If					
	[facility's] care dur on-duty staff and s relocated during th	ing an emergency. If					
	on-duty staff and s relocated during th						
	-	sheltered patients are					
		ne emergency, the [facility]					
	must document th	e specific name and					
	location of the rec	eiving facility or other					
	location.						
	*[For PRTFs at §4	41.184(b), LTC at					
		Ds at §483.475(b), PACE					
	,	licies and procedures. (2)					
		the location of on-duty staff					
	and sheltered resi	dents in the [PRTF's, LTC,					
	ICF/IID or PACE]	care during and after an					
		duty staff and sheltered					
	residents are reloo	-					
		PRTF's, LTC, ICF/IID or					
	-	ment the specific name					
		e receiving facility or other					
	location.						
	*[For Inpatient Ho	spice at §418.113(b)(6):]					
	Policies and proce						
		n from the hospice, which					
		ation of care and treatment					
		s; staff responsibilities;					
	-	ntification of evacuation					
		mary and alternate means					
	of communication assistance.	with external sources of					
		ack the location of hospice					
		ty and sheltered patients in					
		during an emergency. If					
	-	yees or sheltered patients					
		ng the emergency, the					
		ument the specific name					
		e receiving facility or other					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155831	A. BUILDINGB. WING		COMPLETED 05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	D	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				WESTERN AVENUE		
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER	SOU	ГН BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIES	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 COMPLETI	
TAG	location.	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	*[For CMHCs at a procedures. (2) S CMHC, which ind and treatment ner responsibilities; t of evacuation loc alternate means external sources *[For OPOs at § procedures. (2) A documentation th actual donor info confidentiality of information, and availability of rec *[For ESRD at § procedures. (2) S dialysis facility, w responsibilities, a Based on record re facility failed to en policies and proce the location of on- residents in the LT after an emergence	486.360(b):] Policies and a system of medical hat preserves potential and rmation, protects potential and actual donor secures and maintains the ords. 494.62(b):] Policies and cafe evacuation from the hich includes staff and needs of the patients. view and interview, the asure emergency preparedness dures include a system to track duty staff and sheltered C facility's care during and v. If on-duty staff and sheltered	E 0018	E018 1. The facility has an Emerger Preparedness program. The program has a tracking system document locations of patients and staff as a part of the polici	n to s ies	
	LTC facility must and location of the location in accorda	ated during the emergency, the document the specific name receiving facility or other ance with 42 CFR 483.73(b)		and procedures. This includes current face sheet file located the Risk Managers office to assure efficient, current tracking	in	
	(2). This deficient occupants,	practice could affect all		of residents/staff. 2. The facility has identified all		
	Findings include:			residents as having the potent be affected by this deficient practice.	.iai to	
		eview and interview with the raining, Director of		3. Emergency Preparedness manuals have been placed on	1	

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 05/10/2022 155831 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 **BRIARCLIFF HEALTH & REHABILITATION CENTER** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Maintenance, Maintenance Assistant and each nursing unit; all staff has Director of Maintenance from another facility been educated on the plan. Risk on 05/10/22 between 9:45 a.m. and 12:15 p.m., a Manager will provide training to policy and procedure that includes a system to new hires and will present a quarterly review of the plan to all track the location of sheltered residents in the LTC facility's care during and after an emergency staff and will maintain current face was provided, but the policy did not provide a sheets for each resident at all system to track the location for on-duty staff. times for emergency readiness. 4. The Risk Manager will review her new hire and staff education This finding was acknowledged by the Administrator in Training, Director of as well as her update of the face sheet file at the quarterly QAPI Maintenance, Maintenance Assistant and Director of Maintenance from another facility at meeting to assure that facility the time of discovery and again at the exit remains in compliance. conference with Administrator in Training, Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. E 0020 403.748(b)(3), 416.54(b)(2), 418.113(b)(6) SS=F (ii), 441.184(b)(3), 482.15(b)(3), 483.475(b) Bldg. --(3), 483.73(b)(3), 485.625(b)(3), 485.68(b) (1), 485.727(b)(1), 485.920(b)(2), 491.12(b) (1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b) (6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b) (3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b) (1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVO021 Facility ID: 013420

If continuation sheet Page 12 of 86

#### PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ALL TIPLE CO	INSTRUCTION	(Y3) DA7	TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	r í	UILDING	NSTRUCTION	. ,	
IND FLAN	OF CORRECTION	155831		B. WING		COMPLETED 05/10/2022	
		155831	D. W	/ING		05/1	0/2022
NAME OF	PROVIDER OR SUPPLIEI	ξ			ADDRESS, CITY, STATE, ZIP COI	)Е	
					ESTERN AVENUE		
BRIARC	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH	I BEND, IN 46619		
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLET
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		his section. The policies					
		nust be reviewed and					
		every 2 years [annually for					
	-	a minimum, the policies nust address the following:]					
		lust address the following.j					
	[(3) or (1), (2), (6)	Safe evacuation from the					
		cludes consideration of					
		nt needs of evacuees; staff					
	responsibilities; tr	ansportation; identification					
	of evacuation loca	ation(s); and primary and					
	alternate means of	of communication with					
	external sources	of assistance.					
		100 740/h)/2) and ACCa					
		3403.748(b)(3) and ASCs					
	at §416.54(b)(2):]	rom the [RNHCI or ASC]					
	which includes the						
		of care needs of evacuees.					
	(ii) Staff responsib						
	(iii) Transportation						
		of evacuation location(s).					
	(v) Primary and a	ternate means of					
	communication w	ith external sources of					
	assistance.						
		485.68(b)(1), Clinics,					
	-	encies, OPT/Speech at nd ESRD Facilities at					
	§494.62(b)(2):]	nu ESRD Facilities at					
		rom the [CORF; Clinics,					
		encies, and Public Health					
	-	iders of Outpatient Physical					
	-	ech-Language Pathology					
		RD Facilities], which					
		ponsibilities, and needs of					
	the patients.						
	-	Cs at §491.12(b)(1):] Safe					
	evacuation from t	he RHC/FQHC, which					

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155831 B. WING 05/10/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE includes appropriate placement of exit signs; staff responsibilities and needs of the patients. E020 Based on record review and interview, the E 0020 06/17/2022 1. The facility has an Emergency facility failed to ensure emergency preparedness policies and procedures include information for Preparedness program. The safe evacuation from the LTC facility, which program includes policies and includes consideration of care and treatment procedures for safe evacuation needs of evacuees; staff responsibilities; from the facility including all of the required elements of the process. transportation; identification of evacuation location(s): and primary and alternate means of 2. The facility has identified all communication with external sources of residents as having the potential to assistance in accordance with 42 CFR 416.54(c) be affected by this deficient practice. (1). This deficient practice could affect all occupants. 3. Emergency Preparedness manuals have been placed on Findings include: each nursing unit; all staff has been educated on the plan. Risk Based on records review and interview with the Manager will provide training to Administrator in Training, Director of new hires and will present a quarterly review of the plan to all Maintenance, Maintenance Assistant and Director of Maintenance from another facility staff and will maintain current face sheets for each resident at all on 05/10/22 between 9:45 a.m. and 12:15 p.m., the provided EPP policy and procedures times for emergency readiness. 4. The Risk Manager will review documentation did not include a comprehensive her new hire and staff education plan for the safe evacuation of residents. as well as her update of the face sheet file at the guarterly QAPI This finding was acknowledged by the Administrator in Training, Director of meeting to assure that facility Maintenance, Maintenance Assistant and remains in compliance. Director of Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training. Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m. E 0029 403.748(c), 416.54(c), 418.113(c), SS=C 441.184(c), 482.15(c), 483.475(c),

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CV0021

Facility ID: 013420

If continuation sheet

Page 14 of 86

PRINTED: 06/01/2022 FORM APPROVED

STATEME	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (X	OMB NO. 0938-039 (3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155831	B. WING		05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		VESTERN AVENUE H BEND, IN 46619		
_				11 DEND, IN 40019	(775)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
		,	IAG	DEFICIENCE	DATE	
Bldg		02(c), 485.625(c),				
		27(c), 485.920(c),				
	486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c),					
		§485.68(c), §485.625(c), §485.727(c),				
		.,,				
		6.360(c), §491.12(c),				
	§494.62(c).					
	(c) The [facility] r	nust develop and maintain				
		eparedness communication				
	plan that complie	s with Federal, State and				
	local laws and m	ust be reviewed and updated				
	at least every 2 y facilities].	ears [annually for LTC				
	Based on record re	eview and interview, the failed	E 0029	1. The facility has an Emergency	y 06/17/202	
	to review and upda	ew and update the Emergency		Preparedness program. The		
	Preparedness Plan	's (EPP) Communication Plan		program includes a written		
	at least annually ir	ast annually in accordance with 42 CFR		communication plan that has be	en	
	483.73(a). This de	ficient practice could affect		reviewed by the committee and		
	all occupants.			scheduled for an annual review. 2. The facility has identified all		
	Findings include:			residents as having the potentia be affected by this deficient	l to	
	Based on records a	review and interview with the		practice.		
	Administrator in T	raining, Director of		3. Emergency Preparedness		
		ntenance Assistant and		manuals have been placed on		
		enance from another facility		each nursing unit; all staff has		
	on 05/10/22 betwee	en 9:45 a.m. and 12:15 p.m.,		been educated on the plan. Risk	K l	
	the EEP lacked a c	cover page, and no date could		Manager will provide training to		
	be found to show	he EEP's Communication Plan		new hires and will present a		
	dures was reviewe	d and updated within the last		quarterly review of the plan to al	1	
	year. Based on an	interview during records		staff.		
	review, the Mainte	enance Director stated the EEP		4. Risk Manager will inform QAF	2	
	was reviewed rece	ntly but during the survey no		committee of any changes in the	e	
	documentation wa	s provided indicating the EEP's		communication should they occu	ur	
	Communication P	lan was updated within the last		between annual reviews to assu	ire	
	year.			that facility remains in		

ENTERS FO	R MEDICARE & MEDIC	AID SERVICES				(	OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. B	IULTIPLE CO UILDING /ING	ONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIER			5024 V	ADDRESS, CITY, STATE, ZIP CO VESTERN AVENUE	ODE		
BRIARC	LIFF HEALTH & RE	HABILITATION CENTER		SOUT	H BEND, IN 46619			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Administrator in Tr Maintenance, Main Director of Mainten the time of discover conference with Ad Director of Mainten Director of Mainten	knowledged by the aining, Director of tenance Assistant and nance from another facility at ry and again at the exit lministrator in Training, nance, Maintenance Assistant, nance from another facility resentative present at 4:15			compliance.			
E 0030 SS=C Bldg	441.184(c)(1), 483 483.73(c)(1), 484 485.68(c)(1), 485 486.360(c)(1), 49 Names and Conta §403.748(c)(1), §4 (1), §441.184(c)(1) §482.15(c)(1), §4 (1), §484.102(c)(1)	416.54(c)(1), §418.113(c) ), §460.84(c)(1), 33.73(c)(1), §483.475(c) ), §485.68(c)(1), 485.727(c)(1), §485.920(c)						
	an emergency pre plan that complies local laws and mu at least every 2 ye facilities]. The co include all of the f	ust develop and maintain eparedness communication s with Federal, State and est be reviewed and updated ears [annually for LTC mmunication plan must ollowing:]						
	(i) Staff.	ng services under icians						

	FERS FOR MEDICARE & MEDICAID SERVICES							
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CO	ONSTRUCTION	(X3) DA'	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. E	BUILDING		COM	IPLETED	
		155831	B. V	VING		05/*	05/10/2022	
		_		STREET	ADDRESS, CITY, STATE, ZIP (	CODE		
NAME OF	PROVIDER OR SUPPLIE	R		5024 W	/ESTERN AVENUE			
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER		SOUTH	I BEND, IN 46619			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROUTDERIC N. IN OF COL	NECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY	APPROPRIATE	DATE	
	(iv) Other [facilitie	es].						
	(v) Volunteers.							
	*[For Hospitals at	\$482.15(c) and CAHs at						
		communication plan must						
	include all of the f	-						
		ontact information for the						
	following:							
	(i) Staff.							
		ing services under						
	arrangement.	C C						
	(iii) Patients' phys	sicians						
	(iv) Other [hospita	als and CAHs].						
	(v) Volunteers.							
	*[For RNHCIs at §	§403.748(c):] The						
		lan must include all of the						
	following:							
	(1) Names and co	ontact information for the						
	following:							
	(i) Staff.							
		ing services under						
	arrangement.							
		uardian, or custodian.						
	(iv) Other RNHCI	S.						
	(v) Volunteers.							
	*[For ASCs at §4*	16.45(c):] The						
		lan must include all of the						
	following:							
	(1) Names and co	ontact information for the						
	following:							
	(i) Staff.							
	.,	ing services under						
	arrangement.							
	(iii) Patients' phys	sicians.						
	(iv) Volunteers.							
	*[For Hospices at	: §418.113(c):] The						
	communication pl	lan must include all of the			1			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE		
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER		WESTERN AVENUE TH BEND, IN 46619		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	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		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	following:	anta at information for the				
	following:	ontact information for the				
	(i) Hospice emplo	Wees				
		ing services under				
	arrangement.					
	(iii) Patients' phys	icians				
	(iv) Other hospice					
	*[For HHAs at §4	84.102(c):1 The				
	-	an must include all of the				
	following:					
	•	ontact information for the				
	following:					
	(i) Staff.					
	(ii) Entities provid	ing services under				
	arrangement.					
	(iii) Patients' phys	icians.				
	(iv) Volunteers.					
	*[For OPOs at §4					
		an must include all of the				
	following:					
		ontact information for the				
	following:					
	(i) Staff.	ing convisoo under				
		ing services under				
	arrangement. (iii) Volunteers.					
	(iv) Other OPOs.					
	· · /	d donor hospitals in the				
		Service Area (DSA).				
		view and interview, the	E 0030	1. The facility has an Emerger	ncy 06/17/20	
		sure the emergency	2 0000	Preparedness program. The		
		nunication plan includes (1)		program includes a written		
		information for the		communication plan that inclu	des	
	following: (i) Staff	(ii) Entities providing		all the required facility contact	s	
		ngement (iii) Patients'		and has been reviewed by the	•	
		unteers in accordance with 42		committee and scheduled for a	an	
	CFR 483.73(c)(1).	This deficient practice could		annual review.		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		COMPLETED
		155831	B. WING		05/10/2022
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP CODE	
				WESTERN AVENUE	
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER	SOUT	ΓΗ BEND, IN 46619	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	affect all occupant	ts.		2. The facility has identified a	
				residents as having the poter	ntial to
	Findings include:			be affected by this deficient	
		· · · · · · · · · · · · · · · · · · ·		practice.	
		review and interview with the		3. Emergency Preparedness	
		Fraining, Director of ntenance Assistant and		manuals have been placed o each nursing unit; all staff ha	
		enance from another facility		been educated on the plan. F	
		een 9:45 a.m. and 12:15 p.m.,		Manager will provide training	
		paredness plan communication		new hires and will present a	
		ete. The emergency		quarterly review of the plan to	o all
		did not include contact		staff.	
	information for cu	rrent staff, it included contact		4. Risk Manager will inform G	QAPI
		aff who no longer work at the		committee of any changes in	the
		d key essential personnel who		communication should they c	
	now are employed	at the facility.		between annual reviews to a	ssure
				that facility remains in	
		cknowledged by the		compliance.	
		Fraining, Director of ntenance Assistant and			
		enance from another facility at			
		ery and again at the exit			
		dministrator in Training,			
		enance, Maintenance Assistant,			
		ctor of Maintenance from			
	another facility an	d Corporate Representative			
	present at 4:15 p.r	n.			
E 0031		16.54(c)(2), 418.113(c)(2),			
SS=C		32.15(c)(2), 483.475(c)(2),			
Bldg		4.102(c)(2), 485.625(c)(2), 5.727(c)(2), 485.920(c)(2),			
		91.12(c)(2), 494.62(c)(2)			
		ials Contact Information			
		§416.54(c)(2), §418.113(c)			
		(2), §460.84(c)(2),			
		483.73(c)(2), §483.475(c)			
	(2), §484.102(c)	(2), §485.68(c)(2),			
		§485.727(c)(2), §485.920(c)			
	(2), §486.360(c)	2), §491.12(c)(2),			
	1				

PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE C A. BUILDING B. WING		(x3) date survey completed 05/10/2022	
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024 \	TADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE TH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIO DATE	
	§494.62(c)(2).					
	an emergency pr plan that complie local laws and m at least every 2 y facilities]. The co include all of the (2) Contact inform (i) Federal, State emergency prepa (ii) Other sources *[For LTC Faciliti Contact informati (i) Federal, State emergency prepa (ii) The State Lice Agency.	nation for the following: , tribal, regional, and local aredness staff. s of assistance. es at §483.73(c):] (2) fon for the following: , tribal, regional, and local aredness staff. ensing and Certification the State Long-Term Care				
	*[For ICF/IIDs at information for th (i) Federal, State emergency prepa (ii) Other sources (iii) The State Lic Agency. (iv) The State Pro Agency. Based on record re facility failed to er preparedness com Contact informatio Federal, State, trib	§483.475(c):] (2) Contact e following: , tribal, regional, and local aredness staff.	E 0031	E031 1. The facility has an Emerger Preparedness program. The program includes a written communication plan that inclu all of the required facility conta	des	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	î î	SURVEY LETED
AND PLAN	OF CORRECTION	155831	B. WING		-	)/2022
			STRFFT	ADDRESS, CITY, STATE, ZIP CO	-	
NAME OF I	PROVIDER OR SUPPLIE	ER		VESTERN AVENUE		
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER		H BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROMINED'S DI AN OF CODR	FECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	FROFRIATE	DATE
	Licensing and Cer	tification Agency (iii) The		as well as all of the req	uired	
	Office of the State	Long-Term Care Ombudsman		Emergency Officials co	ntact	
	(iv) Other sources	of assistance in accordance		information and has be	en	
	with 42 CFR 483.	73(c) (2). This deficient		reviewed by the commi	ttee and	
	practice could affe	ect all occupants.		scheduled for an annua	al review.	
				2. The facility has ident	ified all	
	Findings include:			residents as having the	potential to	
				be affected by this defic	cient	
	Based on records	review and interview with the		practice.		
		Fraining, Director of		3. Emergency Prepared		
	Maintenance, Mai	ntenance Assistant and		manuals have been pla	ced on	
	Director of Mainte	enance from another facility		each nursing unit; all st	aff has	
	on 05/10/22 betwee	een 9:45 a.m. and 12:15 p.m.,		been educated on the p	olan. Risk	
	the emergency pre-	paredness communication		Manager will provide tra	aining to	
		ed to include contact		new hires and will prese	ent a	
		Federal, State, tribal,		quarterly review of the	plan to all	
	-	emergency preparedness staff		staff.		
		nsing and Certification Agency		4. Risk Manager will inf		
		the State Long-Term Care		committee of any chang	-	
	Ombudsman (iv)	Other sources of assistance.		communication should between annual review	-	
	This finding was a	cknowledged by the		that facility remains in		
	-	Fraining, Director of		compliance.		
		ntenance Assistant and				
		enance from another facility at				
	the time of discov	ery and again at the exit				
		dministrator in Training,				
	Director of Mainte	enance, Maintenance Assistant,				
	an additional Dire	ctor of Maintenance from				
	another facility an	d Corporate Representative				
	present at 4:15 p.n	n.				
0033	403.748(c)(4)-(6	), 416.54(c)(4)-(6),				
SS=F		), 441.184(c)(4)-(6),				
Bldg		483.475(c)(4)-(6),				
2		484.102(c)(4)-(5),				
		), 485.68(c)(4), 485.727(c)				
		)-(6), 491.12(c)(4),				
	494.62(c)(4)-(6)					
	Methods for Sha	ring Information				
						1

PRINTED: 06/01/2022 FORM APPROVED OMB NO 1038 0301

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CON	(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIEI	R EHABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP ( ESTERN AVENUE BEND, IN 46619	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	§418.113(c)(4)-(6) §460.84(c)(4)-(6), §460.84(c)(4)-(6), §483.73(c)(4)-(6), §483.73(c)(4)-(6), §485.625(c)(4)-(6) §485.920(c)(4)-(6). [(c) The [facility] n an emergency pre- plan that complies local laws and mu at least every 2 ye facilities]. The co- include all of the f (4) A method for s medical documen [facility's] care, as health providers to care. (5) A means, in the to release patient under 45 CFR 16- provision is not re §484.102(c), COF (6) [(4) or (5)]A m information about location of patient as permitted under *[For RNHCIs at § for sharing inform documentation for RNHCI's care, as	), §485.727(c)(4), ), §491.12(c)(4), anust develop and maintain eparedness communication s with Federal, State and ust be reviewed and updated ears [annually for LTC mmunication plan must following: sharing information and tation for patients under the anecessary, with other o maintain the continuity of the event of an evacuation, information as permitted 4.510(b)(1)(ii). [This equired for HHAs under RFs under §485.68(c)] eans of providing the general condition and ts under the [facility's] care er 45 CFR 164.510(b)(4).					

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. BUILDING B. WING		DATE SURVEY DMPLETED 5/10/2022	
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION	
TAG	based on the writt by the patient or h representative. *[For RHCs/FQH4 means of providir general condition under the facility's 45 CFR 164.510( Based on record re facility failed to en preparedness comm method for sharing documentation for facility's care, as ne care providers to m (5) A means, in the release resident inf 45 CFR 164.510(b) providing informat condition and locat facility's care as pe 164.510(b)(4) in ac 483.73(c)(4). This affect all occupants Findings include: Based on records m Administrator in T Maintenance, Main Director of Mainte on 05/10/22 betwee the emergency prej not include a comm for sharing informat documentation for facility's care, as ne	Cs at §491.12(c):] (4) A og information about the and location of patients is care as permitted under b)(4). view and interview, the sure the emergency nunication plan includes (4) A information and medical residents under the LTC ecessary, with other health maintain the continuity of care; e event of an evacuation, to formation as permitted under 0(1)(ii); (6) A means of ion about the general ion of residents under the rmitted under 45 CFR coordance with 42 CFR deficient practice could s.	E 0033	<ol> <li>The facility has an Emergency Preparedness program. The program includes a method for sharing information and medical documentation for patients under the facilitys care, as necessary, with other health providers to maintain the continuity of care. The facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan.</li> <li>The facility has identified all residents as having the potential to be affected by this deficient practice.</li> <li>Emergency Preparedness manuals have been placed on each nursing unit, Risk Manager will provide training to new hires and will present a quarterly review of the plan to all staff.</li> <li>Risk Manager will inform QAPI committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance</li> </ol>	DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

If continuation sheet Page 23 of 86

SUMMARY S (EACH DEFICIEN REGULATORY OF his finding was ad dministrator in Tr laintenance, Maint irector of Mainten e time of discove onference with Ad irector of Mainten additional Direc other facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID S 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	EHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL (CLSC IDENTIFYING INFORMATION) Cknowledged by the raining, Director of netenance Assistant and nance from another facility at rry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from 1 Corporate Representative  3.73(c)(8) Sharing Plan with Patients	5024	TADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE H BEND, IN 46619  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETED 05/10/2022 (X5) COMPLETIO DATE
F HEALTH & RE SUMMARY S (EACH DEFICIEN REGULATORY OF his finding was ad dministrator in Th laintenance, Maint irector of Mainten te time of discove onference with Ad irector of Mainten to additional Direc to the facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID S 483.73(c)(8); §4 For LTC Facilitie c) The LTC facilitie	EHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION) cknowledged by the raining, Director of ntenance Assistant and nance from another facility at rry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]	5024 V SOUT ID PREFIX	WESTERN AVENUE H BEND, IN 46619 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO
F HEALTH & RE SUMMARY S (EACH DEFICIEN REGULATORY OF his finding was ad dministrator in Th laintenance, Maint irector of Mainten te time of discove onference with Ad irector of Mainten to additional Direc to the facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID S 483.73(c)(8); §4 For LTC Facilitie c) The LTC facilitie	EHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION) cknowledged by the raining, Director of ntenance Assistant and nance from another facility at rry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]	ID PREFIX	H BEND, IN 46619 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO
(EACH DEFICIEN <u>REGULATORY OF</u> his finding was ac dministrator in Th laintenance, Main irector of Mainten te time of discove onference with Ac irector of Mainten additional Director to ther facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID S 483.73(c)(8); §4 For LTC Facilities c) The LTC facil	ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) cknowledged by the raining, Director of intenance Assistant and nance from another facility at rry and again at the exit dministrator in Training, nance, Maintenance Assistant, itor of Maintenance from 1 Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO
REGULATORY OF his finding was ac dministrator in Tr laintenance, Main irector of Mainten e time of discove onference with Ac irector of Mainten a additional Direc nother facility and resent at 4:15 p.m 33.475(c)(8), 48 IC and ICF/IID 5 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	A LSC IDENTIFYING INFORMATION) eknowledged by the raining, Director of intenance Assistant and nance from another facility at ry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
his finding was ac dministrator in Tr laintenance, Main irector of Mainten e time of discove onference with Ac irector of Mainten additional Direc nother facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID 3 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	cknowledged by the raining, Director of ntenance Assistant and nance from another facility at ry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from 1 Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
dministrator in Tr laintenance, Main irector of Mainten e time of discove onference with Ac irector of Mainten additional Director other facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID 483.73(c)(8); §4 For LTC Facilitie c) The LTC facilitie	raining, Director of ntenance Assistant and nance from another facility at ry and again at the exit dministrator in Training, nance, Maintenance Assistant, otor of Maintenance from 1 Corporate Representative 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
irector of Mainten e time of discove onference with Ac irector of Mainten additional Direc nother facility and resent at 4:15 p.m 33.475(c)(8), 48 FC and ICF/IID 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	nance from another facility at ry and again at the exit dministrator in Training, nance, Maintenance Assistant, tor of Maintenance from 1 Corporate Representative 1. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
e time of discove onference with Ac irector of Mainten additional Direc nother facility and resent at 4:15 p.m 33.475(c)(8), 48 IC and ICF/IID 5 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	ry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
onference with Ac irector of Mainten additional Director other facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID 3 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative a. 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
irector of Mainten additional Direc nother facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	nance, Maintenance Assistant, etor of Maintenance from 1 Corporate Representative 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
n additional Direc nother facility and resent at 4:15 p.m 33.475(c)(8), 48 TC and ICF/IID 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	tor of Maintenance from I Corporate Representative 3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
nother facility and resent at 4:15 p.m 33.475(c)(8), 48 FC and ICF/IID 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	l Corporate Representative  3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
resent at 4:15 p.m 33.475(c)(8), 48 FC and ICF/IID 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	3.73(c)(8) Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
TC and ICF/IID \$ 483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	Sharing Plan with Patients 83.475(c)(8) es at §483.73(c):]			
483.73(c)(8); §4 For LTC Facilitie c) The LTC facil	83.475(c)(8) es at §483.73(c):]			
c) The LTC facil	- , , -			
,	ity must develop and			
aintain an amar	-			
	gency preparedness lan that complies with			
	d local laws and must be			
For ICF/IIDs at {	§483.475(c):]			
,	-			
• • •	•			
•				
	-			
	-			
-		E 0025	F035	06/17/202
		E 0055		
-			Preparedness program	,
			communication plan that include	s
	viewed and upo mmunication p lowing:] For ICF/IIDs at ) The ICF/IIDs at ) The ICF/IID n emergency pro- an that complies cal laws and mul- least every 2 years an must include o A method for se e emergency pl termined is app ents] and their used on record re cility failed to en eparedness plan of aring information	viewed and updated at least annually. The mmunication plan must include all of the lowing:] For ICF/IIDs at §483.475(c):] ) The ICF/IID must develop and maintain emergency preparedness communication an that complies with Federal, State and cal laws and must be reviewed and updated least every 2 years. The communication an must include all of the following:] A method for sharing information from e emergency plan, that the facility has termined is appropriate, with residents [or ents] and their families or representatives. used on record review and interview, the cility failed to ensure the emergency eparedness plan (EPP) includes a method for aring information from the emergency plan	viewed and updated at least annually. The mmunication plan must include all of the lowing:] For ICF/IIDs at §483.475(c):] ) The ICF/IID must develop and maintain emergency preparedness communication an that complies with Federal, State and cal laws and must be reviewed and updated least every 2 years. The communication an must include all of the following:] A method for sharing information from e emergency plan, that the facility has termined is appropriate, with residents [or ents] and their families or representatives. used on record review and interview, the cility failed to ensure the emergency eparedness plan (EPP) includes a method for aring information from the emergency plan	viewed and updated at least annually. The mmunication plan must include all of the lowing:] for ICF/IIDs at §483.475(c):] ) The ICF/IID must develop and maintain emergency preparedness communication an that complies with Federal, State and cal laws and must be reviewed and updated least every 2 years. The communication an must include all of the following:] 0 A method for sharing information from e emergency plan, that the facility has termined is appropriate, with residents [or ents] and their families or representatives. sed on record review and interview, the cility failed to ensure the emergency eparedness plan (EPP) includes a method for

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CO A. BUILDING B. WING	COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O that the facility ha with residents and representatives in 483.73(c)(8). This affect all occupant Findings include: Based on records a Administrator in T	accordance with 42 CFR deficient practice could s. review and interview with the Graining, Director of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) a method for sharing information from the emergency plan, and th the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. 2. The facility has identified all residents as having the potentia be affected by this deficient practico.	nat
	Director of Mainte on 05/10/22 betwee the Emergency Pro- not address a meth contained within t deems appropriate or representatives.	ntenance Assistant and enance from another facility een 9:45 a.m. and 12:15 p.m., eparedness Binder provided did nod for sharing information he EPP Binder that the facility with residents, their families		<ul> <li>practice.</li> <li>3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Risk Manager will provide training to new hires and will present a quarterly review of the plan to al staff.</li> <li>4. Risk Manager will inform QAF</li> </ul>	1
	Administrator in T Maintenance, Mai Director of Mainte the time of discov conference with A Director of Mainte an additional Dire	Training, Director of ntenance Assistant and enance from another facility at ery and again at the exit dministrator in Training, enance, Maintenance Assistant, ctor of Maintenance from d Corporate Representative		committee of any changes in the plan should they occur between annual reviews to assure that facility remains in compliance.	e
E 0036 SS=F Bldg	441.184(d), 482. 483.73(d), 484.1 485.68(d), 485.7 486.360(d), 491. EP Training and §403.748(d), §44 §441.184(d), §46 §483.73(d), §483	., .,			

PRINTED: 06/01/2022 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		-	(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER		5024 WE	DDRESS, CITY, STATE, ZIP CO ESTERN AVENUE BEND, IN 46619	DE		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE		(X5) COMPLETIO
TAG		r LSC IDENTIFYING INFORMATION) 36.360(d), §491.12(d),		TAG	DEFICIENCY			DATE
	§416.54, Hospice §441.184, PACE §482.15, HHAs a §485.68, CAHs a under 485.727, C at §486.360, and Training and test develop and mai preparedness tra that is based on in paragraph (a) assessment at p section, policies paragraph (b) of communication p section. The trai	§403.748, ASCs at e at §418.113, PRTFs at at §460.84, Hospitals at at §484.102, CORFs at at §486.625, "Organizations" CMHCs at §485.920, OPOs I RHC/FHQs at §491.12:] (d) ing. The [facility] must ntain an emergency ining and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, and the olan at paragraph (c) of this ning and testing program d and updated at least every						
	Training and test develop and mai preparedness tra that is based on in paragraph (a) assessment at pa- section, policies paragraph (b) of communication p section. The trai must be reviewed annually.	es at §483.73(d):] (d) ing. The LTC facility must ntain an emergency anining and testing program the emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, and the blan at paragraph (c) of this ning and testing program d and updated at least §483.475(d):] Training and						
	testing. The ICF/	IID must develop and rgency preparedness						

	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/10/2022	
	OVIDER OR SUPPLIE	R EHABILITATION CENTER	5024	TADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE TH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETI DATE	
	the emergency p (a) of this section paragraph (a)(1) procedures at para and the communi- of this section. T program must be least every 2 year the requirements training at §483.4 *[For ESRD Faci Training, testing, dialysis facility m emergency prepara and patient orien on the emergence (a) of this section paragraph (a)(1) procedures at para and the communi- of this section. T orientation progra updated at every 1. Based on record facility failed revio Emergency Prepara and Testing Plan ara with 42 CFR 483.1 could affect all occ Findings include: Based on records for Administrator in T Maintenance, Mainto on 05/10/22 between	lities at §494.62(d):] and orientation. The ust develop and maintain an aredness training, testing tation program that is based y plan set forth in paragraph d, risk assessment at of this section, policies and ragraph (b) of this section, ication plan at paragraph (c) he training, testing and am must be evaluated and 2 years. review and interview, the ewed and updated the edness Plan's (EPP) Training t least annually in accordance 73(a). This deficient practice	E 0036	E036 1. The facility has an Emerger Preparedness plan has a writt testing and training program. 2. The facility has identified all residents as having the potent be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Ri Manager will provide training to new hires and will present a quarterly review of the plan to	tial to	

	R MEDICARE & MEDI				NICTRICTION		MB NO. 0938-0
STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			ì í	(X3) DATE SURVEY	
							PLETED
		155831	B. WINC	j		05/1	0/2022
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TUBLE OF		n in the second s		5024 W	ESTERN AVENUE		
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER		SOUTH	BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID		× 1	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PF	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE DDIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		ГAG	DEFICIENCY)	PRIATE	DATE
	be found to show t	he EPP's Training and Testing			staff.		
	Plan was reviewed	and updated within the last			4. Risk Manager will inform	QAPI	
	year. Based on an	interview during records			committee of any changes	in the	
	review, the Mainte	mance Director stated the EEP			plan should they occur bet	ween	
		ntly but during the survey no			annual reviews to assure th	nat	
	documentation wa			facility remains in complian	ce.		
	Training and Testi	ng Plan was updated within the					
	last year.						
	-	cknowledged by the					
		raining, Director of					
	Maintenance, Main						
	Director of Mainte						
	the time of discove						
	conference with A						
	Director of Mainte						
	Director of Mainte and Corporate Rep						
	p.m.						
	p.m.						
	2. Based on record	review and interview, the					
	facility failed to de						
	-	edness training and testing					
	program that is bas	sed on the emergency plan					
	accordance with 4						
	deficient practice of	could affect all occupants.					
	Findings include:						
	Based on records r	eview and interview with the					
	Administrator in T	raining, Director of					
		ntenance Assistant and					
	Director of Mainte	nance from another facility					
	on 05/10/22 betwee	en 9:45 a.m. and 12:15 p.m.,					
	-	gency Preparedness Plan					
		ain a training and testing					
	program.						
	This finding was a Administrator in T	cknowledged by the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155831 NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER		CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED 05/10/2022	
		5024	ET ADDRESS, CITY, STATE, ZIP ( WESTERN AVENUE TH BEND, IN 46619	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 0037 SS=F Bldg	Maintenance, Mai Director of Mainte the time of discove conference with A Director of Mainte and Corporate Rep p.m. 403.748(d)(1), 44 441.184(d)(1), 48 483.73(d)(1), 48 485.68(d)(1), 48 485.68(d)(1), 48 485.68(d)(1), 48 486.360(d)(1), 48 (1), §441.184(d)( §482.15(d)(1), §4 (1), §444.102(d)( §485.625(d)(1), §4 (1), §486.360(d)( *[For RNCHIs at §416.54, Hospita §486.360, RHC/I (1) Training prog all of the followin (i) Initial training policies and proc existing staff, ind under arrangeme consistent with th (ii) Provide emer training at least e (iii) Maintain doc preparedness tra	ntenance Assistant and enance from another facility at ery and again at the exit dministrator in Training, enance, Maintenance Assistant, enance from another facility presentative present at 4:15 16.54(d)(1), 418.113(d)(1), 32.15(d)(1), 483.475(d)(1), 4.102(d)(1), 485.625(d)(1), 5.727(d)(1), 485.920(d)(1), 9.112(d)(1) gram §416.54(d)(1), §418.113(d) 1), §460.84(d)(1), 483.73(d)(1), §483.475(d) 1), §485.68(d)(1), 5485.727(d)(1), §485.920(d) 1), §491.12(d)(1). §403.748, ASCs at at §482.15, ICF/IIDs at at §484.102, under §485.727, OPOs at FQHCs at §491.12:] gram. The [facility] must do g: in emergency preparedness redures to all new and ividuals providing services ent, and volunteers, heir expected roles. gency preparedness every 2 years. umentation of all emergency ining. staff knowledge of					

	R MEDICARE & MEDICAID SERVICES NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION						OMB NO. 0938-0	
		X1) PROVIDER/SUPPLIER/CLIA	ì í		NSTRUCTION	. ,	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			-	IPLETED	
		155831	B. WI	NG		- 05/1	10/2022	
JAME OF	PROVIDER OR SUPPLIEF	-			DDRESS, CITY, STATE, ZIP CO	DE		
					ESTERN AVENUE			
_	-	HABILITATION CENTER			BEND, IN 46619			
X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		cy preparedness policies						
		re significantly updated,						
		conduct training on the						
	updated policies a	and procedures.						
	*[For Hospices at	§418.113(d):] (1) Training.						
		do all of the following:						
	(i) Initial training ir	emergency preparedness						
	policies and proce							
	existing hospice e	mployees, and individuals						
	providing services	under arrangement,						
	consistent with the	eir expected roles.						
	(ii) Demonstrate s							
	emergency proce	dures.						
	(iii) Provide emerg	ency preparedness						
	training at least ev							
	(iv) Periodically re							
	emergency prepa	redness plan with hospice						
	employees (includ	ling nonemployee staff),						
	with special emph	asis placed on carrying out						
	the procedures ne	ecessary to protect patients						
	and others.							
	(v) Maintain docur	mentation of all emergency						
	preparedness trai							
	(vi) If the emerger	ncy preparedness policies						
	and procedures a	re significantly updated,						
	the hospice must	conduct training on the						
	updated policies a	ind						
	procedures.							
	*IFor PRTFs at 84	41.184(d):] (1) Training						
		TF must do all of the						
	following:							
	-	emergency preparedness						
		edures to all new and						
	1 · ·	viduals providing services						
	-	nt, and volunteers,						
	consistent with the							
		ning, provide emergency						
		ning every 2 years.						
		mig orony z youro.	1				1	

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/10/2022	
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER				5024 W	DDRESS, CITY, STATE, ZIP ESTERN AVENUE BEND, IN 46619	CODE	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	DATE
	emergency proce (iv) Maintain doc preparedness tra (v) If the emerge and procedures a the PRTF must of updated policies *[For PACE at §4 organization mus (i) Initial training policies and proc existing staff, ind services under a participants, and their expected ro (ii) Provide emer training at least of (iii) Demonstrate emergency proce participants of wi whom to contact (iv) Maintain doc (v) If the emerge and procedures a the PACE must of updated policies *[For LTC Facilitit Training Program all of the followin (i) Initial training policies and proc existing staff, ind under arrangeme consistent with th (ii) Provide emer training at least a	umentation of all emergency aining. ncy preparedness policies are significantly updated, conduct training on the and procedures. 460.84(d):] (1) The PACE at do all of the following: in emergency preparedness cedures to all new and lividuals providing on-site rrangement, contractors, volunteers, consistent with les. gency preparedness every 2 years. staff knowledge of edures, including informing hat to do, where to go, and in case of an emergency. umentation of all training. ency preparedness policies are significantly updated, conduct training on the and procedures. tes at §483.73(d):] (1) n. The LTC facility must do g: in emergency preparedness edures to all new and ividuals providing services ent, and volunteers, neir expected role. gency preparedness					

TATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		, í	IULTIPLE CO UILDING	NSTRUCTION		(X3) DATE SURVEY COMPLETED 05/10/2022		
	155831			/ING				
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP C	CODE		
BRIARCLIFF HEALTH & REHABILITATION CENTER					ESTERN AVENUE BEND, IN 46619			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF COD	RECTION	(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	preparedness tra (iv) Demonstrate emergency proce	staff knowledge of						
		§485.68(d):](1) Training. do all of the following:						
		training in emergency						
	preparedness po	licies and procedures to all						
	new and existing	staff, individuals providing	1					
		rrangement, and volunteers,						
		neir expected roles.						
		gency preparedness						
	training at least e							
		umentation of the training.						
		staff knowledge of						
		edures. All new personnel and assigned specific						
		egarding the CORF's						
		within 2 weeks of their first						
		ining program must include						
		location and use of alarm						
		nals and firefighting						
	equipment.							
		ency preparedness policies						
	.,	are significantly updated,						
	the CORF must of	conduct training on the						
	updated policies	and procedures.						
		85.625(d):] (1) Training						
		AH must do all of the						
	following:							
		in emergency preparedness						
		edures, including prompt	1					
		tinguishing of fires,						
		here necessary, evacuation						
		onnel, and guests, fire cooperation with firefighting						
		norities, to all new and						
		ividuals providing services	1					
	-	ent, and volunteers,						

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155831		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/10/2022	
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER		5024	T ADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE TH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLET DATE
	(ii) Provide emerger training at least ef (iii) Maintain docu (iv) Demonstrate emergency proce (v) If the emerger and procedures at the CAH must co- updated policies *[For CMHCs at 4] The CMHC must emergency proper procedures to all individuals provide arrangement, and their expected ro- documentation of must demonstrate emergency proce CMHC must prov- preparedness train Based on record re- facility failed to co- Emergency Prepar LTC facility must Initial training in ef policies and proce- staff, individuals pro- arrangement, and their expected role preparedness train Maintain document preparedness train Maintain document preparedness train Maintain document preparedness train Knowledge of emer accordance with 42	umentation of the training. staff knowledge of edures. ency preparedness policies are significantly updated, nduct training on the and procedures. §485.920(d):] (1) Training. provide initial training in aredness policies and new and existing staff, ling services under d volunteers, consistent with les, and maintain f the training. The CMHC e staff knowledge of edures. Thereafter, the	E 0037	E037 1. The facility has an Emerger Preparedness plan that provid the signatures of attendance for the the initial emergency preparedness training as well calendar scheduled annual review, update and training ear year. 2. The facility has identified all residents as having the potent be affected by this deficient practice. 3. Emergency Preparedness manuals have been placed on each nursing unit; all staff has been educated on the plan. Ri	les or as a ach l tial to

AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155831		A. BUILDING B. WING	<u></u>		19leted 10/2022
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024	T ADDRESS, CITY, STATE, ZIP COI WESTERN AVENUE TH BEND, IN 46619	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 0039 SS=C Bldg	Findings include: Based on records r Administrator in T Maintenance, Main Director of Mainte on 05/10/22 betwee no documentation documentation to s knowledge of the I This finding was a Administrator in T Maintenance, Main Director of Mainte the time of discove conference with A Director of Mainte an additional Direc another facility and present at 4:15 p.m 403.748(d)(2), 44 441.184(d)(2), 48 485.68(d)(2), 485 486.360(d)(2), 48 486.360(d)(2), 48 486.360(d)(2), 48 486.360(d)(2), 48 (2), §460.84(d)(2) §483.73(d)(2), §4 (2), §494.62(d)(2) *[For ASCs at §4 OPO, "Organizat CMHCs at §485.5	eview and interview with the fraining, Director of intenance Assistant and nance from another facility en 9:45 a.m. and 12:15 p.m., of annual EEP training and no show staff could demonstrate EPP was available for review. cknowledged by the fraining, Director of intenance Assistant and nance from another facility at ery and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative h. (6.54(d)(2), 418.113(d)(2), 32.15(d)(2), 483.475(d)(2), 4.102(d)(2), 485.625(d)(2), 5.727(d)(2), 485.920(d)(2), 91.12(d)(2), 494.62(d)(2) irements (18.113(d)(2), §441.184(d) ), §482.15(d)(2), (83.475(d)(2), (485.920(d)(2), §491.12(d)		Manager will provide trai new hires and will presen quarterly review of the pl staff. 4. Risk Manager will info committee of any change plan should they occur b annual reviews to assure facility remains in compli	nt a lan to all rm QAPI es in the etween e that	

PRINTED: 06/01/2022 FORM APPROVED OMB NO 1038 0301

NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA								
STATEME	NT OF DEFICIENCIES				NSTRUCTION	(X3) DA	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	.DING		COMPLETED		
		155831	B. WIN	G		05/	/10/2022	
NAME OF	PROVIDER OR SUPPLIEI	R		STREET A	DDRESS, CITY, STATE, ZIP CC	DE		
					ESTERN AVENUE			
		HABILITATION CENTER			BEND, IN 46619			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	(2) Testing. The [1	facility] must conduct						
	exercises to test t	he emergency plan						
	annually. The [fac	cility] must do all of the						
	following:							
	(i) Participate in a	full-scale exercise that is						
		l every 2 years; or						
	(A) When a comr							
	· · /	onduct a facility-based						
		e every 2 years; or						
		ility] experiences an actual						
	• • •	ade emergency that						
		n of the emergency plan,						
		empt from engaging in its						
	next required com							
	facility-based fund							
	the onset of the a	-						
		Iditional exercise at least						
		posite the year the						
		onal exercise under						
	paragraph (d)(2)(i							
		nay include, but is not						
	limited to the follo	-						
		scale exercise that is						
		l or individual, facility-based						
	functional exercis							
	(B) A mock disast							
		ercise or workshop that is						
	-	and includes a group						
	discussion using a							
	-	emergency scenario, and						
		statements, directed						
		pared questions designed						
	to challenge an er	mergency plan.						
	(iii) Analyze the [f	acility's] response to and						
	maintain docume	ntation of all drills, tabletop						
	exercises, and en	nergency events, and revise						
	the [facility's] eme	ergency plan, as needed.						
	*[For Hospices at	/18 113(d)·1						

AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2022			
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER				STREET A 5024 WI SOUTH	DE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE		(X5) COMPLETI
TAG	REGULATORY O	PR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			DATE
	the patient's hom conduct exercises at least annually following: (i) Participate in community base (A) When a com accessible, cond based functional (B) If the hospice man-made emer activation of the is exempt from e full scale commu individual facility following the ons (ii) Conduct an a years, opposite t functional exercise of this section is include, but is not (A) A second full community-base functional exercise (B) A mock disa (C) A tabletop e led by a facilitato discussion using clinically-relevan a set of problem messages, or pro- to challenge an e (3) Testing for ho- care directly. Th exercises to test per year. The ho- (i) Participate in	ster drill; or xercise or workshop that is or and includes a group a narrated, t emergency scenario, and statements, directed epared questions designed						

TERS FO	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-0	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIPLE C	ONSTRUCTION	(X3) D	ATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. I	BUILDING		CC	OMPLETED	
		155831	В. V	WING		05	05/10/2022	
NAME OF	PROVIDER OR SUPPLIEF	ι {			ADDRESS, CITY, STATE, ZIP C	ODE		
		HABILITATION CENTER						
	-		T		H BEND, IN 46619			
X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)	
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		nunity-based exercise is						
		nduct an annual individual						
		tional exercise; or						
		experiences a natural or						
	-	ency that requires						
		mergency plan, the						
		t from engaging in its next						
		community based or						
		tional exercise following						
	the onset of the e							
		dditional annual exercise						
	that may include,	but is not limited to the						
	following:							
	(A) A second full-	scale exercise that is						
	community-based							
	functional exercise	e; or						
	(B) A mock disas	ter drill; or						
	(C) A tabletop ex	ercise or workshop led by a						
	facilitator that incl	udes a group discussion						
	using a narrated,	clinically-relevant						
	emergency scena	rio, and a set of problem						
	statements, direct	ed messages, or prepared						
	questions designe	ed to challenge an						
	emergency plan.							
	(iii) Analyze the h	ospice's response to and						
	maintain documer	ntation of all drills, tabletop						
	exercises, and em	nergency events and revise						
	the hospice's eme	ergency plan, as needed.						
	-	l41.184(d), Hospitals at						
	§482.15(d), CAHs							
		PRTF, Hospital, CAH] must						
		to test the emergency plan						
		ne [PRTF, Hospital, CAH]						
	must do the follow	5						
	(i) Participate in a	an annual full-scale						
	exercise that is co	ommunity-based; or						
	(A) When a comm	nunity-based exercise is						
	not accessible, co	nduct an annual individual,						
	2-99) Previous Versions Ob			21 Facility	/ ID: 013420 If con		Page	

	NT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. E	MULTIPLE CC BUILDING VING	DNSTRUCTION		(X3) DATE SURVEY COMPLETED 05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CO	DE		
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER			/ESTERN AVENUE I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE	
	<ul> <li>(B) If the [PRTF, experiences an a emergency that remergency plan, engaging in its necommunity based functional exercise emergency even (ii) Conduct exercise or and the limited to the follor (A) A second full community-based facility-based functional exercise facility-based functional exercise or and the follor (B) A method (C) A tabletor is led by a facilitate discussion, using clinically-relevant a set of problem messages, or present to challenge an everties and revise the [far needed.</li> <li>*[For PACE at §4 (2) Testing. The conduct exercise at least annually must do the follor (i) Participate in exercise that is conduct exercise at least annually must do the follor (i) Participate in exercise that is conduct exercise that is conducted the conduct exercise that is conducted the conduct exercise t</li></ul>	actual natural or man-made requires activation of the the [facility] is exempt from ext required full-scale d or individual, facility-based se following the onset of the t. : an [additional] annual that may include, but is not owing: Il-scale exercise that is d or individual, a notional exercise; or lock disaster drill; or op exercise or workshop that ator and includes a group g a narrated, t emergency scenario, and statements, directed epared questions designed emergency plan. the [facility's] response to cumentation of all drills, es, and emergency events acility's] emergency plan, as 460.84(d):] PACE organization must es to test the emergency plan . The PACE organization						

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155831	` ´	JLTIPLE CON ILDING NG			(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER		5024 WE	ddress, city, state, zip ESTERN AVENUE BEND, IN 46619	CODE		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			DATE
	requires activation the PACE is exer- required full-scal individual, facility following the onser- (ii) Conduct 2 years opposite functional exercise of this section is but is not limited (A) A second full community-base based functional (B) A mock disa (C) A tabletop e- led by a facilitato discussion, using clinically-relevan a set of problem messages, or pro- to challenge an e- (iii) Analyze the maintain docume exercises, and e- the PACE's eme *[For LTC Facilitit (2) The [LTC fac- to test the emerge facility, ICF/IID] r (i) Participate in exercise that is co- (A) When a comm- not accessible, co- facility-based fur- (B) If the [LTC fac-	I-scale exercise that is d or individual, a facility exercise; or ster drill; or xercise or workshop that is or and includes a group g a narrated, t emergency scenario, and statements, directed epared questions designed emergency plan. PACE's response to and entation of all drills, tabletop mergency events and revise rgency plan, as needed. tes at §483.73(d):] ility] must conduct exercises pency plan at least twice per nannounced staff drills ency procedures. The [LTC must do the following: an annual full-scale community-based; or munity-based exercise is onduct an annual individual,						

F ADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE 'H BEND, IN 46619  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETI
DEFICIENCY)	DATE
	ity ID: <b>013420</b> If continuation shee

							OMB NO. 0938-03	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING		COM	<b>IPLETED</b>	
		155831	B. W	/ING		05/*	05/10/2022	
NAME OF	PROVIDER OR SUPPLIEF	ι {			ADDRESS, CITY, STATE, ZIP C	ODE		
		HABILITATION CENTER			'ESTERN AVENUE I BEND, IN 46619			
_	-							
X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A		COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		scale community-based or						
	individual, facility-	based functional exercise						
	following the onse	et of the emergency event.						
	(ii) Conduct an ad	ditional annual exercise						
	that may include,	but is not limited to the						
	following:							
	(A) A second full-	scale exercise that is						
	community-based							
	facility-based fund	tional exercise; or						
	(B) A mock disast	er drill; or						
	(C) A tabletop exe	ercise or workshop that is						
		and includes a group						
	discussion, using							
	-	emergency scenario, and						
	-	tatements, directed						
		pared questions designed						
	to challenge an er							
	-	CF/IID's response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
		rgency plan, as needed.						
	*[For HHAs at §48	34.102]						
		e HHA must conduct						
		he emergency plan at						
		e HHA must do the						
	following:							
	-	full-scale exercise that is						
	community-based							
	-	ommunity-based exercise						
		conduct an annual						
		based functional exercise						
	every 2 years; or.							
		A experiences an actual						
		ade emergency that						
		0						
		n of the emergency plan,						
		ot from engaging in its next						
		community-based or						
		based functional exercise						
	I TOILOWING the onse	t of the emergency event.						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULT A. BUILD B. WING		STRUCTION	co	(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	ER	5	024 WE	DRESS, CITY, STATE, ZIP COD STERN AVENUE BEND, IN 46619	Ē		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	SHOULD BE CON		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T	AG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
	(ii) Conduct an a	dditional exercise every 2						
		he year the full-scale or						
		se under paragraph (d)(2)(i)						
	of this section is	-						
		ot limited to the following:						
		d full-scale exercise that is						
		d or an individual,						
		ictional exercise; or						
	. ,	disaster drill; or						
	(C) A tableto	op exercise or workshop that						
	is led by a facilitation	ator and includes a group						
	discussion, using	g a narrated,						
	clinically-relevan	t emergency scenario, and						
	a set of problem	statements, directed						
	messages, or pre	epared questions designed						
	to challenge an e							
	-	HHA's response to and						
		entation of all drills, tabletop						
		mergency events, and revise						
		gency plan, as needed.						
	*[For OPOs at §4	-						
	(d)(2) Testing. Th	he OPO must conduct						
	exercises to test	the emergency plan. The						
	OPO must do the	e following:						
	(i) Conduct a pap	per-based, tabletop exercise						
	or workshop at le	east annually. A tabletop						
	exercise is led by	y a facilitator and includes a						
		, using a narrated, clinically						
		ncy scenario, and a set of						
		ents, directed messages, or						
		ons designed to challenge an						
	1 · · ·	If the OPO experiences an						
		man-made emergency that						
		on of the emergency plan,						
		npt from engaging in its next						
		exercise following the onset						
	of the emergency	-						
		OPO's response to and						
	maintain docume	entation of all tabletop		1				

	T OF HEALTH AND HU R MEDICARE & MEDIO				FORM APPROVED OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155831	B. WING		05/10/2022
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	R		VESTERN AVENUE	
		EHABILITATION CENTER		H BEND, IN 46619	
		ENABLEMATION CENTER	3001		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		mergency events, and revise			
	-	d OPO's] emergency plan,			
	as needed.				
	**	0.7401			
	*[ RNCHIs at §40	-			
		ne RNHCI must conduct			
		the emergency plan. The			
	RNHCI must do t	-			
		per-based, tabletop exercise			
		A tabletop exercise is a			
		led by a facilitator, using a y-relevant emergency			
		set of problem statements,			
dire des		es, or prepared questions			
	-	enge an emergency plan.			
	-	NHCI's response to and			
		entation of all tabletop			
		mergency events, and revise			
		ergency plan, as needed.			
		eview and interview, the	E 0039	E039	06/17/202
		onduct exercises to test the	12 00000	1. The facility has an Emergency	
		least twice per year. The		Preparedness plan includes the	,
		ust do all of the following:		annual tabletop and full-scale	
		n annual full-scale exercise		exercise.	
	that is community-	-based; or		2. The facility has identified all	
	a. When a commu	nity-based exercise is not		residents as having the potentia	l to
	accessible, conduc	t an annual individual,		be affected by this deficient	
	facility-based func	tional exercise.		practice.	
		acility experiences an actual		3. Emergency Preparedness	
		de emergency that requires		manuals have been placed on	
		mergency plan, the ICF/IID		each nursing unit; all staff has	
		from engaging its next		been educated on the plan. Risk	
	-	community-based or		Manager will provide training to	
	-	-based full-scale functional		new hires and will present a	
		following the onset of the		quarterly review of the plan to al	
	actual event.			staff.	
		ditional exercise that may		4. Risk Manager will inform QAF	
	include, but is not limited to the following	-		committee of any changes in the	
				I when a last of the set of a second back of the second	1
	a. A second full-sc	ale exercise that is or an individual, facility-based		plan should they occur between annual reviews to assure that	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

If continuation sheet

Page 43 of 86

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	ì í	E SURVEY LETED
AND PLAN	OF CORRECTION	155831	A. BUILDING B. WING			)/2022
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R	5024 W	VESTERN AVENUE		
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER	SOUTH	H BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	functional exercise			facility remains in complian	ce.	
	b. A mock disaster					
	-	ise or workshop that is led by				
		cludes a group discussion led				
		ng a narrated, clinically				
	•	y scenario, and a set of				
	-	s, directed messages, or				
		designed to challenge an				
	emergency plan.					
		CF/IID facility's response to				
		mentation of all drills, tabletop				
		rgency events, and revise the				
acc	-	emergency plan, as needed in				
		2 CFR 483.475(d)(2). This				
	deficient practice of	could affect all occupants.				
	Findings include:					
	Based on records r	eview and interview with the				
		raining, Director of				
		ntenance Assistant and				
		nance from another facility				
		en 9:45 a.m. and 12:15 p.m.,				
		documentation of an actual				
		uired full-scale exercise. The				
	- · ·	vidence of COVID 19 being				
	used as an exercise	e of choice (table-top).				
	This finding was a	cknowledged by the				
	•	raining, Director of				
		ntenance Assistant and				
	Director of Mainte	nance from another facility at				
	the time of discove	ery and again at the exit				
	conference with A	dministrator in Training,				
		nance, Maintenance Assistant,				
	an additional Direct	ctor of Maintenance from				
	another facility and	d Corporate Representative				
	present at 4:15 p.n	1.				

CVOO21 Facility ID: 013420

If continuation sheet

Page 44 of 86

PRINTED:

06/01/2022

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DA COM	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE			5024 W	ADDRESS, CITY, STATE, ZIP CO ESTERN AVENUE BEND, IN 46619	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
E 0041 SS=F Bldg	§482.15(e) Condii (e) Emergency an The hospital must standby power sy emergency plan s this section and ir procedures plan s (1)(i) and (ii) of thi §483.73(e), §485. (e) Emergency an The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 (1) Emergency gener generator must be with the location r Health Care Facil Tentative Interim 12-3, TIA 12-4, TI Safety Code (NFF Interim Amendme 12-3, and TIA 12- new structure is b structure or buildin 482.15(e)(2), §48 Emergency gener The [hospital, CAI implement the em inspection, testing requirements four	<ul> <li>LTC Emergency Power tion for Participation: d standby power systems.</li> <li>implement emergency and stems based on the et forth in paragraph (a) of the policies and set forth in paragraphs (b) s section.</li> <li>625(e) d standby power systems.</li> <li>and the CAH] must ency and standby power the emergency plan set (a) of this section.</li> <li>83.73(e)(1), §485.625(e)</li> <li>ator location. The e located in accordance equirements found in the ties Code (NFPA 99 and Amendments TIA 12-2, TIA A 12-5, and TIA 12-6), Life PA 101 and Tentative nts TIA 12-1, TIA 12-2, TIA</li> <li>4), and NFPA 110, when a uilt or when an existing</li> </ul>					

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	UI TIPI E CC	ONSTRUCTION		MB NO. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	ì í	JILDING	INSTRUCTION	COMPLETED		
ANDILAN	OF CORRECTION	155831	B. WI			05/10/2022		
		133831	<i>D</i> . <i>W</i>			03/1	0/2022	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE			
					ESTERN AVENUE			
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER		SOUTH	I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		33.73(e)(3), §485.625(e)(3)						
		erator fuel. [Hospitals, CAHs						
		s] that maintain an onsite						
		wer emergency generators						
		n for how it will keep er systems operational					1	
		jency, unless it evacuates.						
	during the enterg	jency, unless it evacuates.						
	*[For hospitals at	t §482.15(h), LTC at						
		CAHs §485.625(g):]						
	•	corporated by reference in						
		pproved for incorporation						
		he Director of the Office of						
		ster in accordance with 5						
	-	ld 1 CFR part 51. You may						
	obtain the materi	al from the sources listed						
	below. You may	inspect a copy at the CMS						
	Information Reso	ource Center, 7500 Security						
	Boulevard, Baltin	nore, MD or at the National						
		cords Administration						
	· · ·	rmation on the availability of						
	this material at N	ARA, call 202-741-6030, or						
	go to:	<i>"</i>						
		/es.gov/federal_register/cod						
		ulations/ibr_locations.html.						
		this edition of the Code are						
		eference, CMS will publish e Federal Register to						
	announce the ch	0						
		Protection Association, 1						
	Batterymarch Pa							
	,	69, www.nfpa.org,						
	1.617.770.3000.	, www.mpa.org,						
		alth Care Facilities Code,						
	.,	ued August 11, 2011.						
		erim amendment (TIA) 12-2						
		ied August 11, 2011.					1	
		IFPA 99, issued August 9,						
	2012.						1	

STATEME	R MEDICARE & MEDIO NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	ì, î	LDING	INSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED <b>05/10/2022</b>	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER			'ESTERN AVENUE I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE	
	2013. (v) TIA 12-5 to N 2013. (vi) TIA 12-6 to N 2014. (vii) NFPA 101, L edition, issued Ai (viii) TIA 12-1 to 1 11, 2011. (ix) TIA 12-2 to N 30, 2012.	NFPA 101, issued August						
	22, 2013. (xi) TIA 12-4 to N 22, 2013. (xiii) NFPA 110, S and Standby Pov including TIAs to 2009	FPA 101, issued October FPA 101, issued October Standard for Emergency ver Systems, 2010 edition, chapter 7, issued August 6,	E 004	41	E041		06/17/20	
	facility failed to in power system insp maintenance requi Care Facilities Coo Code in accordance This deficient prace occupants. Findings include: Based on records r Administrator in T Maintenance, Main Director of Mainten on 05/10/22 betwee the facility provide of the emergency §	nplement the emergency ection, testing, and rements found in the Health de, NFPA 110, and Life Safety e with 42 CFR 483.73(e)(2). tice could affect all review and interview with the raining, Director of intenance Assistant and mance from another facility en 9:45 a.m. and 12:15 p.m., ed documentation for testing generator, however, could not ation of consistent monthly		-	<ol> <li>The facility has an Emerger Preparedness that has:         <ul> <li>a) the required emergency a standby power systems to me the requirements of the facilit emergency plan and corresponding policies and procedures</li> <li>b) emergency power systems plans in place to maintain sat operations while sheltering in place</li> <li>c) maintains an onsite fuel so in accordance with NFPA 110 their generator</li> <li>d) has a plan for how to keep generator operational during emergency, unless the facility plans to evacuate</li> </ul> </li> </ol>	nd eet ys s or fe Durce D for the an		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG	СОМ	(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	EHABILITATION CENTER	502	EET ADDRESS, CITY, STATE, ZIP C 24 WESTERN AVENUE 10TH BEND, IN 46619	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE A	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE	
K 0000	Administrator in T Maintenance, Mai Director of Mainte the time of discove conference with A Director of Mainte an additional Dire	acknowledged by the Fraining, Director of Intenance Assistant and enance from another facility at ery and again at the exit dministrator in Training, enance, Maintenance Assistant, ctor of Maintenance from d Corporate Representative n.		<ol> <li>The facility has idem residents as having the be affected by this defi practice. 3. Emergency Preparedness manuals placed on each nursing staff has been educate plan. Risk Manager will training to new hires ar present a quarterly rev plan to all staff.</li> <li>Risk Manager will in committee of any chan plan should they occur annual reviews to assu facility remains in comp</li> </ol>	e potential to cient / s have been g unit; all ed on the I provide nd will iew of the form QAPI ges in the between ire that		
Bldg. 01	Licensure Survey Department of Her CFR 483.90(a). Survey Date: 05/1 Facility Number: Provider Number: AIM Number: 20 At this Life Safety and Rehabilitation compliance with F in Medicare/Media 483.90(a), Life Sa edition of the Nati Association (NFP.	013420 155831 1293620 v Code survey, Briarcliff Health c Center was found not in Requirements for Participation caid, 42 CFR Subpart fety from Fire, and the 2012 onal Fire Protection A) 101, Life Safety Code b, Existing Health Care	K 0000	K000 Attached is the plan of for the Life Safety Cod Emergency Preparedn Survey conducted at B Health & Rehabilitation 2022. The facility is res requesting desk review this survey.	e with ess K000 riarcliff n May 10, spectfully		

STATEME	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATI COMF	MB NO. 0938-0391 E SURVEY PLETED D/2022
	PROVIDER OR SUPPLIE	EHABILITATION CENTER	5024	ET ADDRESS, CITY, STATE, ZIP COD WESTERN AVENUE TH BEND, IN 46619	E	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	LD BE	(X5) COMPLETION DATE
K 0211 SS=F Bldg. 01	determined to be of and was fully sprin alarm system with corridors, all areas hard-wired smoke sleeping rooms. T 111 and had a cen survey. At the tim 200 were unoccup significant and con All areas where re were sprinklered a services were sprin Quality Review con NFPA 101 Means of Egress Means of Egress Means of Egress Aisles, passagew discharges, exit l in accordance with means of egress free of all obstruct emergency, unlet through 18/19.2. 18.2.1, 19.2.1, 7. Based on observat failed to ensure all were continuously obstructions. LSC into the required w wheeled equipment following condition (a) The wheeled en	ompleted on 05/17/22 = - General = - General vays, corridors, exit ocations, and accesses are th Chapter 7, and the is continuously maintained ctions to full use in case of ss modified by 18/19.2.2 11. 1.10.1 ion and interview, the facility corridor means of egresses, maintained free of 19.2.3.4 (4) states projections width shall be permitted for t, provided that all of the	K 0211	K211 What corrective actions w accomplished for those re found to have affected by deficient practice; Boxes identified will be to a designated storage How the facility will identi resident having the potent affected by the same defi	esidents the <b>moved</b> space. fy other tial to be	06/17/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	X3) DATE SURVEY COMPLETED 05/10/2022
	PROVIDER OR SUPPL	ER REHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP CODE /ESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
( 0222 SS=F Bldg. 01	<ul> <li>(b) The health ca and training prog the wheeled equi emergency.</li> <li>(c) The wheeled e following: <ol> <li>Equipment in u</li> <li>Medical emergiii. Patient lift and This deficient pra facility.</li> </ol> </li> <li>Findings include:</li> <li>Based on observation facility tour with Director of Main and Director of Main and Director of Main and Director of Main stored.</li> <li>This finding was Administrator in Maintenance, Ma Director of Main the time of discorticon conference with A Director of Main an additional Dir another facility a present at 4:15 p.</li> <li>NFPA 101 Egress Doors Egress Doors</li> </ul>	re occupancy fire safety plan ram address the relocation of pment during a fire or similar quipment is limited to the se and carts in use gency equipment not in use d transport equipment actice affects all residents in the the Administrator in Training, tenance, Maintenance Assistant faintenance from another 22 between 12:15 p.m. and 0-hall dayroom area at the end ere were at least 12 large boxes acknowledged by the Training, Director of intenance from another facility at very and again at the exit Administrator in Training, tenance, Maintenance Assistant, ector of Maintenance from and Corporate Representative		practice and what corrective action will be taken; Facility will be toured to check for additional boxes in corridors and hallways and correct any identified deficiencies. None found. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recu- Inservice will be done with maintenance and central sup personnel to ensure boxes ar not stored in corridors and hallways throughout the facility. Maintenance/designe will do rounds once a week for 8 weeks to ensure no boxes a present. How will the corrective action b monitored to ensure the deficien practice will not recur, i.e. what quality assurance programs will be put into place; Maintenance/designee will present 3 months of audit results to QAPI committee an progress will be assessed an adjusted as needed.	k s ur: ply e e or nre e ent i l l d

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NTERS FO	R MEDICARE & MEDI	CAID SERVICES				(	OMB NO. 0938-0	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		NSTRUCTION	r í	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	01		IPLETED	
		155831	B. WI	B. WING		05/*	05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	P	<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP COD	E		
I WINE OF	ind viblik on borreit				ESTERN AVENUE			
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER		SOUTH	BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	D BE	COMPLET	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	not be equipped	with a latch or a lock that						
	requires the use	of a tool or key from the						
	egress side unle	ss using one of the following						
	special locking a							
	CLINICAL NEED	S OR SECURITY THREAT						
	LOCKING							
		cking arrangements for the						
		needs of the patient are						
		ocking device shall be						
		h door and provisions shall						
		rapid removal of occupants						
		ol of locks; keying of all						
	-	ried by staff at all times; or						
		le means available to the						
	staff at all times.							
		2.2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6							
	SPECIAL NEED							
	-	cking arrangements for the						
		he patient are used, all of						
	-	ecurity Locking requirements						
		addition, the locks must be						
	-	nat fail safely so as to						
		s of power to the device; the						
		ted by a supervised						
		ler system and the locked						
	· ·	ed by a complete smoke						
		or is constantly monitored						
		cation within the locked						
	space): and both	the sprinkler and detection						
		inged to unlock the doors						
	upon activation.	5						
		2.2.2.5.2, TIA 12-4						
	DELAYED-EGR							
	ARRANGEMEN							
	Approved, listed	delayed-egress locking						
		d in accordance with						
	-	e permitted on door						
		ng low and ordinary hazard						
	1	•						

	R MEDICARE & MEDI				NIGTRUCTION		B NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. WI		<u>01</u>		
		155831	D. W1	<u> </u>		05/10/	2022
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					ESTERN AVENUE		
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ngs protected throughout by					
		pervised automatic fire					
	-	or an approved, supervised					
	automatic sprinkl	-					
	18.2.2.2.4, 19.2.2						
		ROLLED EGRESS					
	LOCKING ARRA						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted. 18.2.2.2.4, 19.2.2	2.2.4					
		BY EXIT ACCESS					
	LOCKING ARRA						
		it access door locking in					
	-	7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		tection system and an					
		vised automatic sprinkler					
	system.	·					
	18.2.2.2.4, 19.2.2	2.2.4					
		vation and interview, the	K 02	222	K222 -1		06/17/20
	facility failed to er	sure the means of egress			What corrective actions will be		
	through courtyard	exits was readily accessible			accomplished for those resider	nts	
	for residents without	ut a clinical diagnosis			found to have affected by the		
	requiring specializ	ed security measures. Doors			deficient practice;		
	within a required r	neans of egress shall not be			Padlocks to gates in the		
		tch or lock that requires the			surrounding courtyards will b	)e	
		from the egress side unless			placed such that they		
		d by LSC 19.2.2.2.4.					
	-	ngements shall be permitted in			are accessible		
		9.2.2.2.5.2. This deficient			from the side facing the		
	-	ct all residents and staff at the			building for emergency exit		
	facility.				purposes.		
					How the facility will identify oth		
	Findings include:				resident having the potential to		
					affected by the same deficient		
		ion and interview during the			practice and what corrective		
	-	ne Administrator in Training,			action will be taken;		
	Director of Mainte	nance, Maintenance Assistant			All combination locks on the		

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155831 B. WING 05/10/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 **BRIARCLIFF HEALTH & REHABILITATION CENTER** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) and Director of Maintenance from another exterior will be tested to ensure facility on 05/10/22 between 12:15 p.m. and proper code is known and 3:10 p.m., the gates exiting from the facilities posted appropriately. two courtyards (Therapy Courtyard and What measures will be put into Courtyard with the Gazebo) to the public way, place or what systemic changes were equipped with combination locks. When will be made to ensure that the random staff were asked if they knew the deficient practice does not recur: combination 3 of 3 staff were not familiar, Inservice will be done with all stating they would just ask someone. staff regarding correct codes to combination locks and codes Additionally, the courtyard gate from the Main Therapy Courtyard to the public way was locked will be posted at nurse's with a combination lock on the outside of the stations. Maintenance will gate and was not accessible from inside the interview 5 staff × 8 weeks to courtyard. The Assistant Maintenance Director ensure successful education(s) stated that was done so that when the mower of staff. people arrived they could come in to mow How will the corrective action be without collecting someone from the facility to monitored to ensure the deficient let them in. practice will not recur, i.e. what quality assurance programs will This finding was acknowledged by the be put into place; Administrator in Training, Director of Maintenance/designee will Maintenance, Maintenance Assistant and present 3 months of audit results to QAPI committee and Director of Maintenance from another facility at the time of discovery and again at the exit progress will be assessed and conference with Administrator in Training, adjusted as needed. Director of Maintenance, Maintenance Assistant, an additional Director of Maintenance from K222-2 another facility and Corporate Representative What corrective actions will be present at 4:15 p.m. accomplished for those residents 2. Based on observation and Interview, the found to have affected by the facility failed to ensure all delayed egress deficient practice; locking arrangements were installed in Egress door with delayed lock accordance with LSC 7.2.1.6.1(3) which states release mechanism near the an irreversible process shall release the lock in salon has been transitioned to the direction of egress within 15 seconds, or 30 a standard code-input locking seconds where approved by the authority having mechanism by removing

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the following conditions:

jurisdiction, upon application of a force to the

release device required in 7.2.1.5.10 under all of

Event ID:

CV0021

Facility ID: 013420

If continuation sheet

Page 53 of 86

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signage.

How the facility will identify other resident having the potential to be

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/10/2022
	ROVIDER OR SUPPLI	ER REHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP CODE VESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICE REGULATORY ( (a) The force shall	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) l not be required to exceed 15	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) affected by the same deficient	DATE
	<ul> <li>continuously app</li> <li>(c) The initiation</li> <li>activate an audible</li> <li>door opening.</li> <li>(d) Once the lock</li> <li>application of for</li> <li>relocking shall be</li> </ul>	Il not be required to be lied for more than 3 seconds. of the release process shall e signal in the vicinity of the has been released by the ce to the releasing device, by manual means only. This could affect 35 residents.		practice and what corrective action will be taken; All egress doors with delaye lock releases will be tested a repaired. What measures will be put inte place or what systemic chang will be made to ensure that the deficient practice does not reconstruct Maintenance staff will be	nd o es e ur:
	facility tour with Director of Maint and Director of M facility on 05/10/ 3:10 p.m., faciliti courtyard, near th second delayed e 3 times by the As When the exit do process to release This finding was Administrator in Maintenance, Ma Director of Maint the time of discov conference with A	tion and interview during the the Administrator in Training, enance, Maintenance Assistant laintenance from another 22 between 12:15 p.m. and es exit door to the gazebo e Salon, equipped with a 15 gress failed to work when tested sistant Maintenance Director. ors were tested the irreversible the lock was not initiated. acknowledged by the Training, Director of intenance Assistant and enance from another facility at very and again at the exit Administrator in Training, enance, Maintenance from ad Corporate Representative		educated on proper function of delayed-release locks and vendor contact for repair. Egress doors will be audited once a week × 8 weeks. How will the corrective action monitored to ensure the defici practice will not recur, i.e. wha quality assurance programs w be put into place; Maintenance/designee will present 3 months of audit results to QAPI committee an progress will be assessed a adjusted as needed.	be ent it ill
	3.1-19(b)				
	2-99) Previous Versions	Obsolete Event ID: (	CVOO21 Facility	ID: 013420 If continuation s	heet Page 54 of 86

 PRINTED:
 06/01/2022

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 OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155831	A. BUILDING B. WING	<u>01</u>	completed 05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
TO HALL OF	I KO VIDEK OK SOTTELE			ESTERN AVENUE		
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER	SOUTH	HBEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
0271	NFPA 101					
SS=E	Discharge from E					
Bldg. 01	Discharge from E					
		arranged in accordance				
		s a level walking surface				
	• .	isions of 7.1.7 with respect				
	•	vation and shall be				
	maintained free of	of obstructions. Additionally,				
	the exit discharge	e shall be a hard packed				
	all-weather trave	l surface.				
	18.2.7, 19.2.7					
	Based on observat	ion and interview, the facility	K 0271	K271	06/17/2022	
	failed to ensure all	exit discharges had a level		What corrective actions will be		
	walking surface, w	vere free of obstructions, and		accomplished for those residen	ts	
	constructed of hard	d packed all-weather travel		found to have affected by the		
	surface in accordan	nce with CMS Survey and		deficient practice;		
	Certification Lette	r 05-38. This deficient		Exit discharge from 300-hall v	vill	
	practice could affe	ect 25 residents.		be leveled-out or ramped and		
				the cracks will be filled to		
	Findings include:			even-out surface. How the facility will identify othe	er	
	Based on observat	ion and interview during the		resident having the potential to		
		he Administrator in Training,		affected by the same deficient		
		enance, Maintenance Assistant		practice and what corrective		
		aintenance from another		action will be taken:		
		2 between 12:15 p.m. and		All exit discharges will be		
	-	discharge from the 300-Hall,		checked to ensure they are		
		the concrete where it met the		level and free of cracks.		
	U U	uneven with approximately a		What measures will be put into		
	-	ation creating a trip hazard.		place or what systemic change		
				will be made to ensure that the		
	This finding was a	cknowledged by the		deficient practice does not recu		
		raining, Director of		All exit discharges will be		
		ntenance Assistant and		checked to ensure they are		
		enance from another facility at		level and free of cracks.		
		ery and again at the exit		How will the corrective action b	e	
		dministrator in Training,		monitored to ensure the deficie	nt	
		enance, Maintenance Assistant,		practice will not recur, i.e. what		
		ctor of Maintenance from		quality assurance programs wil		
	another facility and	d Corporate Representative	1	be put into place;		

	R MEDICARE & MEDI			ECONCEPTION		MB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<sup>3</sup> <u>01</u>			
		155831	B. WING		05/1	0/2022	
NAME OF I	PROVIDER OR SUPPLIE	ER		EET ADDRESS, CITY, STATE, ZIP COI	DE		
				4 WESTERN AVENUE			
BRIARCI		EHABILITATION CENTER	500	JTH BEND, IN 46619			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX	<sup>×</sup>	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APP	ULD BE PROPRIATE	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION)	TAG			DATE	
	present at 4:15 p.m	1.		Maintenance/designee			
	3.1-19(b)			present 3 months of au results to QAPI commit			
	5.1-19(0)						
				progress will be asses	seu anu		
				adjusted as needed.			
< 0341	NFPA 101						
SS=E	Fire Alarm Syste	m - Installation					
Bldg. 01	Fire Alarm Syste	m - Installation					
	A fire alarm syste	em is installed with systems					
	and components	approved for the purpose in					
	accordance with	NFPA 70, National Electric					
	Code, and NFPA	72, National Fire Alarm					
	Code to provide	effective warning of fire in					
		uilding. In areas not					
	-	upied, detection is installed					
		n control unit. In new					
		ction is also installed at					
		ance circuit power					
		upervising station					
		pment. Fire alarm system					
	-	ansmission paths are					
	monitored for inte						
	18.3.4.1, 19.3.4.		17 02 41	K341		0.6/17/000	
		ion and interview, the facility of 1 fire alarm systems was	K 0341	What corrective actions	will be	06/17/202	
		ance with 19.3.4.1. NFPA 72,		accomplished for those r			
		n spaces served by air handling		found to have affected b			
	-	shall not be located where air		deficient practice;	y the		
		ration of the detectors. This		Smoke alarms in 200-ha	all will be		
		could affect 5 staff on the 200		placed at a uniform height			
	hall.	sand affect 5 suff on the 200		How the facility will ident	-		
				resident having the poter			
	Findings include:			affected by the same de			
				practice and what correct			
	Based on observat	ion and interview during the		action will be taken;			
		he Administrator in Training,		All smoke detections s	ystems		
		enance, Maintenance Assistant		will be inspected throug			
		aintenance from another		the facility for additiona			
		2 between 12:15 p.m. and		unevenly places units.			

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

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

OMB NO. 0938-0391 X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 4 - - 0 0 4

NAME OF	PROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE	
BRIARC	LIFF HEALTH & REHABILITATION CENTER		ITH BEND, IN 46619	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC PRIATE DATE
mo	3:10 p.m., the smoke detectors located on the		What measures will be put i	
	200 hallway were attached in unequal location.		place or what systemic char	
	Some were attached to the concrete ceiling and		will be made to ensure that	the
	others were attached to the drop ceiling. The		deficient practice does not r	
	entire 200 hallway was under remodel/renovation		Audits of instances of une	-
	and missing most of the drop ceiling tiles. The		placed smoke detectors w	
	varying height installation of the smoke appliances could impede the system's ability to		done by maintenance /des once a week × 8 weeks to	ignee
	report to the panel accurately in a smoke event.		ensure compliance.	
	report to the panel accurately in a shoke event.		How will the corrective action	on be
	This finding was acknowledged by the		monitored to ensure the def	
	Administrator in Training, Director of		practice will not recur, i.e. w	/hat
	Maintenance, Maintenance Assistant and		quality assurance programs	; will
	Director of Maintenance from another facility at		be put into place;	
	the time of discovery and again at the exit		Maintenance/designee will	
	conference with Administrator in Training, Director of Maintenance, Maintenance Assistant,		present 3 months of audit results to QAPI committee	
	an additional Director of Maintenance from		progress will be assessed	
	another facility and Corporate Representative		adjusted as needed.	
	present at 4:15 p.m.			
	3.1-19(b)			
< 0345	NFPA 101			
SS=F	Fire Alarm System - Testing and			
Bldg. 01	Maintenance			
	Fire Alarm System - Testing and			
	Maintenance A fire alarm system is tested and maintained			
	in accordance with an approved program			
	complying with the requirements of NFPA 70,			
	National Electric Code, and NFPA 72,			
	National Fire Alarm and Signaling Code.			
	Records of system acceptance, maintenance			
	and testing are readily available.			
	9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	17 00 15	KDAE	
	Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems	K 0345	K345 What corrective actions will	be 06/17/20
	was maintained in accordance with 9.6.1.3. LSC		accomplished for those resi	
	9.6.1.3 requires a fire alarm system to be		found to have affected by th	
			1	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE			5024 W	ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		SOUT	I BEND, IN 46619		
X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE PRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	installed, tested, and	nd maintained in accordance			deficient practice;		
	with NFPA 70, Na	ational Electrical Code and			Fire alarm testing were an		
	NFPA 72, Nationa	al Fire Alarm Code. This			be performed, and reports	will	
	deficient practice	could affect all occupants.			be added to a revised and		
					up-to-date Life Safety bind	ler	
	Findings include:				with clearly marked dates		
					on-file.		
	Based on records	review and interview with the			How the facility will identify	other	
	Administrator in T	Fraining, Director of			resident having the potentia		
	Maintenance, Maintenance Assistant and				affected by the same deficie		
	· · · · · · · · · · · · · · · · · · ·	enance from another facility			practice and what corrective		
	on 05/10/22 between 9:45 a.m. and 12:15 p.m., no documentation was provided for review showing the annual and semi-annual fire alarm report. No Fire Alarm system testing reports				action will be taken;		
					Review and organization of	of	
					previous year of fire alarm		
					testing will be done.		
	-	review for days prior to			What measures will be put	into	
		the onset or the COVID 19			place or what systemic cha		
		onstrate that the Fire Alarm			will be made to ensure that	-	
		inspected prior to the COVID			deficient practice does not i		
	Pandemic.	inspected prior to the COVID			Maintenance staff will be		
					trained on putting togethe	r and	
	This finding was a	acknowledged by the			keeping a life safety binde		
	-	Fraining, Director of			readily viewable paper co		
		ntenance Assistant and			Life Safety book will be au		
		enance from another facility at			once a week × 3 months, o		
		ery and again at the exit			a month × 6 months, and		
		dministrator in Training,			quarterly afterwards to ke	an	
		enance, Maintenance Assistant,			compliance.	εh	
		ctor of Maintenance from			How will the corrective action	n ho	
					monitored to ensure the def		
	-	d Corporate Representative					
	present at 4:15 p.m	11.			practice will not recur, i.e. w		
	2 1 10(1-)				quality assurance programs	o vviii	
	3.1-19(b)				be put into place;	i	
					Maintenance/designee wil	I	
					present 3 months of audit		
					results to QAPI committee		
					progress will be assessed	and	
					adjusted as needed.		

FORM CMS-2567(02-99) Previous Versions Obsolete

CVOO21 Facility ID: 013420

Page 58 of 86

If continuation sheet

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER: 155831	A. BUILDING B. WING	<u>01</u>	COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	R R EHABILITATION CENTER	5024 \	ADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE H BEND, IN 46619	1	
(X4) ID PREFIX TAG	(EACH DEFICIE)	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIO DATE	
< 0351 SS=E Bldg. 01	by construction ty throughout by an sprinkler system 13, Standard for the Systems. In Type I and II con- protection measure substituted for sp areas where state prohibit sprinklers In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprint Standard for Instate Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, Based on observatification observatification heads were not obsection 19.3.5.1 states sprint minimize obstructif 8.5.5.2 and 8.5.5.3 be provided to ensure hazard. Sections 8. permit continuous obstructions less the below the sprinkler plane more than 18 deflector that prevention.	<ul> <li>Installation</li> <li>Installation</li> <li>Ind hospitals where required approved automatic n accordance with NFPA the Installation of Sprinkler</li> <li>Installation of Sprinkler</li> <li>Instruction, alternative res are permitted to be rinkler protection in specific e or local regulations</li> <li>Iklers are not required in patient sleeping rooms</li> <li>It he closet does not exceed</li> <li>Sprinkler coverage covers at as required by NFPA 13, allation of Sprinkler</li> <li>Installation of</li></ul>	K 0351	K351 What corrective actions will be accomplished for those reside found to have affected by the deficient practice; 500-hall janitors closet wirin conduit will be moved out of the plane in which it obstruct the operation of the sprinkle system. How the facility will identify oth resident having the potential to affected by the same deficient practice and what corrective action will be taken; All other sprinkler systems with	ents g ts r ner o be	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE COMPL		
		155831	B. WING			05/10/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
		EHABILITATION CENTER		WESTERN AVENUE H BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DEOUDEDIS DE AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE	
				be checked for obstructions			
	Findings include:			which hinder operation.			
				What measures will be put into			
		ion and interview during the		place or what systemic change			
		ne Administrator in Training,		will be made to ensure that the			
		nance, Maintenance Assistant aintenance from another		deficient practice does not rec			
		2 between 12:15 p.m. and		Maintenance/designee will a facility for any obstructed	uait		
		Hall Janitors Closet equipped		sprinkler heads and fix any			
	with 1 sidewall spi			units affected.			
	-	rinkler head was obstructed		How will the corrective action	he		
	· ·	installed in front of the		monitored to ensure the defici			
		hin 2-3 inches. Based on		practice will not recur, i.e. what			
	-	ne of observation, the		quality assurance programs w			
		ctor acknowledged the		be put into place;			
	aforementioned sp	rinkler head was obstructed.		Maintenance/designee will present 3 months of audit			
	This finding was a	cknowledged by the		results to QAPI committee a	nd		
		raining, Director of		progress will be assessed a	nd		
	Maintenance, Main	ntenance Assistant and		adjusted as needed.			
	Director of Mainte	nance from another facility at					
	the time of discove	ery and again at the exit					
	conference with A	dministrator in Training,					
		nance, Maintenance Assistant,					
		ctor of Maintenance from					
		d Corporate Representative					
	present at 4:15 p.n	1.					
	3.1-19(b)						
<b>&lt;</b> 0355	NFPA 101						
SS=E	Portable Fire Ext	-					
Bldg. 01	Portable Fire Ext						
		nguishers are selected,					
		ed, and maintained in					
		NFPA 10, Standard for					
	Portable Fire Ext	-					
	18.3.5.12, 19.3.5		TZ 02.55	K255(4)		0.0117/000	
		vation and interview, the	K 0355	K355(1) What corrective actions will be		06/17/202	
	lacinty failed to er	sure all portable fire		what corrective actions will be	-		

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155831 B. WING 05/10/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 **BRIARCLIFF HEALTH & REHABILITATION CENTER** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) extinguishers were installed in accordance with accomplished for those residents NFPA 10, Standard for Portable Fire found to have affected by the Extinguishers, 2010 Edition. Section 6.1.3.4 deficient practice; The identified fire extinguisher states portable fire extinguishers other than will be affixed to the wall in an wheeled extinguishers shall be installed using any of the following means. (1) Securely on a appropriate manner or will be hanger intended for the extinguishers. (2) In the disposed of appropriately. bracket supplied by the extinguisher How the facility will identify other manufacture. (3) In a listed bracket approved for resident having the potential to be affected by the same deficient such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area practice and what corrective but could affect staff in the basement area. action will be taken: Facility at large will be toured Findings include: for additional fire extinguisher not mounted to the wall and will Based on observation and interview during the be corrected in similar fashion. facility tour with the Administrator in Training, What measures will be put into Director of Maintenance, Maintenance Assistant place or what systemic changes and Director of Maintenance from another will be made to ensure that the facility on 05/10/22 between 12:15 p.m. and deficient practice does not recur: 3:10 p.m., an ABC portable fire extinguisher in Maintenance/designee will the basement maintenance area was sitting on the check facility for non-compliant floor and was unsecured. Based on interview at fire extinguishers once a week the time of observation, the Maintenance × 4 weeks and correct any Director stated it was a spare. findings. How will the corrective action be This finding was acknowledged by the monitored to ensure the deficient Administrator in Training, Director of Maintenance, Maintenance Assistant and practice will not recur. i.e. what Director of Maintenance from another facility at quality assurance programs will the time of discovery and again at the exit be put into place; conference with Administrator in Training, Maintenance/designee will Director of Maintenance, Maintenance Assistant, present 3 months of audit an additional Director of Maintenance from results to QAPI committee and another facility and Corporate Representative progress will be assessed and present at 4:15 p.m. adjusted as needed. 2. Based on observation and interview, the K355(2) What corrective actions will be facility failed to inspect all portable fire extinguishers in the facility each month. NFPA accomplished for those residents 10, Standard for Portable Fire Extinguishers, found to have affected by the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CV0021

Facility ID: 013420

If continuation sheet

Page 61 of 86

PRINTED: 06/01/2022 FORM APPROVED

OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 155831	(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 05/10/2022
	PROVIDER OR SUPPLI	ER REHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP CODE VESTERN AVENUE 1 BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) DBE COMPLETIC DATE
	Section 7.2.1.2 st inspected either n electronic device 30-day intervals. inspection or elece extinguishers sha following items: (1) Location in de (2) No obstruction (3) Pressure gaug operable range or (4) Fullness deter for self expelling- cartridge-operated (5) Condition of t and nozzle for wh (6) Indicator for r using pushto-test Section 7.2.4.1 st inspections shall extinguishers insp require corrective requires where at inspections are co inspection are co inspections shall attached to the fin checklist maintain method. Section be kept to demon monthly inspectio deficient practice hall. Findings include:	ates fire extinguishers shall be nanually or by means of an / system at a minimum of Section 7.2.2 states periodic tronic monitoring of fire Il include a check of at least the esignated place in to access or visibility e reading or indicator in the position mined by weighing or hefting type extinguishers, and pump tanks ires, wheels, carriage, hose, ueeled extinguishers pressure indicators. ates personnel making manual keep records of all fire beeted, including those found to action. Section 7.2.4.3 least monthly manual inducted, the date the manual rformed and the initials of the g the inspection shall be 7.2.4.4 requires where manual be kept on a tag or label e extinguisher, on an inspection ned on file, or by an electronic 7.2.4.5 requires records shall strate that at least the last 12 ons have been performed. This could affect staff in the 200		deficient practice; Fire extinguisher on 200- will be inspected monthly How the facility will identify resident having the potent affected by the same defice practice and what corrective action will be taken; All fire extinguishers will continue to be inspected replaced/recharged, if necessary, monthly. What measures will be put place or what systemic chain will be made to ensure that deficient practice does not Maintenance/designee will floor plan and use the flo as a guide to audit facility extinguishers. Map will b updated quarterly to ensure new extinguishers are minispection. How will the corrective act monitored to ensure the deepractice will not recur, i.e. quality assurance program be put into place; Maintenance/designee will progress will be assessed adjusted as needed.	hall /. / other ial to be ient //e and t into anges t the recur: ill ising a or plan / e ure no issing ion be eficient what as will ill t ue and
	Based on observa	tion and interview during the			

PRINTED: 06/01/2022

FORM APPROVED

STATEME	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION					(X3) DATE SURVEY		
	OF CORRECTION	· /		A. BUILDING <u>01</u>			COMPLETED	
		155831		B. WING			05/10/2022	
				STREET AI	DDRESS, CITY, STATE, ZIP COI	DE		
NAME OF	NAME OF PROVIDER OR SUPPLIER			5024 WESTERN AVENUE				
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER		SOUTHI	BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	JLD BE PROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		ГAG	DEFICIENCY)		DATE	
		he Administrator in Training,						
	Director of Mainte	enance, Maintenance Assistant						
	and Director of M	aintenance from another						
	facility on 05/10/2	2 between 12:15 p.m. and						
	3:10 p.m., the mor	nthly and annual inspection tag						
	on the ABC fire ex	xtinguisher located in the 200						
		nentation of recent monthly						
	inspections.							
	This finding was a	cknowledged by the						
	Administrator in T							
	Maintenance, Mai							
	Director of Mainte							
	the time of discov							
	conference with A							
	Director of Mainte							
	an additional Dire							
	another facility an							
	present at 4:15 p.m							
	3.1-19(b)							
K 0363	NFPA 101							
SS=E	Corridor - Doors							
Bldg. 01	Corridor - Doors							
0	Doors protecting	corridor openings in other						
		closures of vertical						
		or hazardous areas resist						
		moke and are made of 1 3/4						
		d core wood or other						
		of resisting fire for at least						
		rs in fully sprinklered smoke						
		re only required to resist the						
		e. Corridor doors and doors ing flammable or						
		0						
		erials have positive latching						
		latches are prohibited by						
	-	These requirements do not						
		spaces that do not contain						
	Tiammable or cor	mbustible material.						
	1		1	1			1	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING		COMPLETED 05/10/2022	(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024	f address, city, state, zip codi WESTERN AVENUE TH BEND, IN 46619	3		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) en bottom of door and floor	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COM	(X5) APLETIO DATE	
	covering is not ex doors complying if provided with a the door closed w applied. There is closing of the door release when the are permitted. Not unlimited height a meeting 19.3.6.3 frames shall be a other materials in unless the smoke sprinklered. Fixe are allowed per & compartments th area or fire resist window assembl 19.3.6.3, 42 CFF 483, and 485 Show in REMAR fire protection rat devices, etc. Based on observat failed to ensure all the passage of smo could affect 15 res Findings include: Based on observat facility tour with t Director of Mainte and Director of M facility on 05/10/2 3:10 p.m., the follow	Acceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is a no impediment to the brs. Hold open devices that e door is pushed or pulled onrated protective plates of are permitted. Dutch doors .6 are permitted. Door abeled and made of steel or a compliance with 8.3, e compartment is d fire window assemblies 8.3. In sprinklered ere are no restrictions in ance of glass or frames in ies. & Parts 403, 418, 460, 482, KS details of doors such as ings, automatics closing ion and interview, the facility corridor doors would resist oke. This deficient practice	K 0363	K363 What corrective actions w accomplished for those re- found to have affected by deficient practice; The identified four doors both have correct hardw installed and be adjusted repaired for a proper sea How the facility will identifi resident having the potent affected by the same defini- practice and what correct action will be taken; All doors will be inspect	rill be esidents the s will vare d or al. iy other tial to be cient ive	17/20	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155831			(X2) MULTIPLE CO A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 05/10/2022			
	NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION			
	<ul> <li>(EACH DEFICIENT REGULATORY OR REGULATORY OR</li> <li>A) A 1/4 inch hole latching hardware in Office.</li> <li>B) Two 1/4 inch hol the latching hardware in Office.</li> <li>B) Two 1/4 inch hol the latching hardware value of the latching hardware value of the latching hardware value of the stairwer of the stai</li></ul>	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) through the door above the in the Director of Nursing les through the door above re in the Activities Storage e through the door where was missing on the 600 Hall through the door where vas missing in the Laundry rell. knowledged by the aining, Director of tenance Assistant and hance from another facility at ry and again at the exit ministrator in Training, hance, Maintenance Assistant, for of Maintenance from Corporate Representative	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ensure a seal is identifiable an no penetrating holes are noted in their current state throughout the facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Maintenance personnel will be educated to acknowledge doors with either penetrative holes and/or missing hardware regardless of vicinity to residents, as items in need of repair. Audits will be performe throughout the facility once every other month for 3 months, and quarterly afterwards to check for penetrations in doors. How will the corrective action be monitored to ensure the deficien practice will not recur, i.e. what quality assurance programs will be put into place; Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed.	completion DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

If continuation sheet Page 65 of 86

PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 06/01/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION NU 155831		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 05/10/2022	
	PROVIDER OR SUPPLIEI	R EHABILITATION CENTER	5024 V	STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION	
TAG	terminate at an at are not required in ducted HVAC sys sprinkler system in compartments ad 19.3.7.3, 8.6.7.1( Describe any med system in REMAF Based on observati failed to ensure all protected to mainta each smoke barrier requires smoke bar accordance with LS minimum ½ hour f Section 8.5.2.1 requires smoke bar accordance with LS minimum ½ hour f Section 8.5.2.1 requires and the smoke barrier continuous from ar wall, from a floor the barrier to a smoke bar combination thereous penetrations for call pipes, tubes, vents, accommodate elect and communication wall, floor, or floor constructed as a smilling membrane of barrier assembly, sl or material capable of smoke. This def staff and at least 16 Findings include: Based on observati facility tour with the Director of Mainter and Director of Mainter and Director of Mainter	chanical smoke control RKS. on and interview, the facility smoke barriers walls were in the smoke resistance of . LSC Section 19.3.7.5 riers to be constructed in SC Section 8.5 and shall have a ire resistive rating. LSC uires smoke barriers to be a outside wall to an outside o a floor, or from a smoke barrier, or by use of a of. 8.5.6.2 requires bles, cable trays, conduits, wires, and similar items to rical, mechanical, plumbing, as systems that pass through a	тад К 0372	K372 What corrective actions will be accomplished for those resider found to have affected by the deficient practice; Drywall will be patched and/o placed at the mentioned area using the appropriate materia for life safety compliance. How the facility will identify oth resident having the potential to affected by the same deficient practice and what corrective action will be taken; Facility will be checked for other smoke barrier penetrations and repair any findings. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not rect Maintenance/designee will be audit facility for areas that ne drywall patching or placement All noted areas of damage will be reported on a facility map. Audits will be performed onc monthly × 3 months, quarter × a year to keep compliance. How will the corrective action to monitored to ensure the deficient	o be o be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

If continuation sheet Page 66 of 86

	R MEDICARE & MEDIC					IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155831		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/10/2022			
	PROVIDER OR SUPPLIE		5024 W	ADDRESS, CITY, STATE, ZIP CODE		
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER	SOUT	H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETIO DATE
	completely sealed passage of smoke; A. The 600 Hall T approximately a 8 B. Above the drop the double door set smoke wall was m trunk line. This finding was a Administrator in T Maintenance, Main Director of Mainte the time of discove conference with Ad Director of Mainte an additional Director	walls which would resist the V room office had a inch x 5 inch hole in the wall. ceiling in the 300 hall, near , approximately 1/3rd of the issing near the HVAC metal cknowledged by the raining, Director of atenance Assistant and nance from another facility at rry and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative		practice will not recur, i.e. wh quality assurance programs be put into place; Maintenance/designee will present 3 months of audit results to QAPI committee a progress will be assessed adjusted as needed.	will	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Bu Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that Nonrated protect are permitted. Do fixed fire window are self-closing o require latching, a swing in the direct opening provides	ilding Spaces - Smoke ilding Spaces - Smoke parriers are 1-3/4-inch thick od-core doors or of resists fire for 20 minutes. ve plates of unlimited height ors are permitted to have assemblies per 8.5. Doors r automatic-closing, do not and are not required to ction of egress travel. Door a minimum clear width of nging or horizontal doors.				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	R: A. BUILDING <u>01</u> B. WING		01	COMPLETED 05/10/2022	
		155831					
NAME OF PROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATE, ZIP CODE	-	
THE OF I	NO TIDER OR SOITEE			5024 V	VESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	EHABILITATION CENTER		SOUTH	H BEND, IN 46619		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE CROSS-REFERENCED TO THE APPROI		ATE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	<b>-</b>	DATE
	19.3.7.6, 19.3.7.8	3, 19.3.7.9					
		vation and interview, the	K 0	374	K374(1)		06/17/202
	facility failed to en	sure all corridor doors had no			What corrective actions will b	е	
	impediment to close	sing and latching into the door			accomplished for those reside	ents	
	frame and would re	esist the passage of smoke.			found to have affected by the		
	This deficient prac	tice could affect up to 25			deficient practice;		
	staff, visitors and r	esidents.			300-hall smoke doors will be		
				repaired and aligned such the	nat		
	Findings include:				the doors create a proper		
				seal.			
	Based on observati			How the facility will identify ot			
	facility tour with the Administrator in Training,				resident having the potential		
	Director of Maintenance, Maintenance Assistant				affected by the same deficien	t	
	and Director of Maintenance from another				practice and what corrective		
	facility on 05/10/22			action will be taken;			
	3:10 p.m., the doub			All other smoke doors will b	е		
		completely into the			inspected and tested to ens	ure	
		st the passage of smoke,			a proper seal.		
	leaving approximation	tely a 3 inch gap.					
					K374(2)		
	-	cknowledged by the			What corrective actions will b		
		raining, Director of			accomplished for those reside		
		ntenance Assistant and			found to have affected by the		
		nance from another facility at			deficient practice;		
		ery and again at the exit			Smoke doors on the 200-ha		
		dministrator in Training,			will be replaced with doors	hat	
		nance, Maintenance Assistant,			have appropriate fire-rating		
		ctor of Maintenance from			labels and are rated for at le		
		d Corporate Representative			20 minutes. All obstructions		
	present at 4:15 p.m	1.			be removed so door can op	en	
					and close freely.		
					How the facility will identify ot		
		vation and interview, the			resident having the potential		
		sure 1 of over 10 sets of			affected by the same deficien	t	
		s had a fire protection rating			practice and what corrective		
		tes and would not resist the			action will be taken;		
		This deficient practice could			All other smoke doors in fac	liity	
	affect 3 staff.				will be inspected for the		
					appropriate fire rating label.		
	Findings include:				What measures will be put int	0	

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155831 B. WING 05/10/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) place or what systemic changes Based on observation and interview during the will be made to ensure that the facility tour with the Administrator in Training, deficient practice does not recur: Director of Maintenance, Maintenance Assistant Maintenance/designee will and Director of Maintenance from another check smoke doors throughout facility on 05/10/22 between 12:15 p.m. and facility once quarterly to check 3:10 p.m., the facility was unable to provide for a proper seal between evidence that the double door set with the upper doors. How will the corrective action be 1/3 of each door made with glass on the 200 hall monitored to ensure the deficient provided at least a 20 minute fire protection rating. The door set lacked fire rating labels. practice will not recur. i.e. what quality assurance programs will The door set also did not close completely to resist the passage of smoke. A dangling exit sign be put into place; above the door set prevented the doors from Maintenance/designee will fully closing. The identification rating labels on present 3 months of audit the aforementioned door set could not be located results to QAPI committee and and not other documentation was provided to progress will be assessed and demonstrate the doors rating. adjusted as needed. What measures will be put into This finding was acknowledged by the Director place or what systemic changes will be made to ensure that the of Plant Operations at the time of observation and again at the exit conference with the Director deficient practice does not recur: Maintenance/designee will of Plant Operations and Administrator on 08/26/20 at 5:00 p.m. check smoke doors throughout facility once quarterly to check This finding was acknowledged by the for a proper seal between Administrator in Training, Director of doors. How will the corrective action be Maintenance, Maintenance Assistant and monitored to ensure the deficient Director of Maintenance from another facility at the time of discovery and again at the exit practice will not recur, i.e. what conference with Administrator in Training, quality assurance programs will Director of Maintenance, Maintenance Assistant, be put into place; an additional Director of Maintenance from Maintenance/designee will another facility and Corporate Representative present 3 months of audit present at 4:15 p.m. results to QAPI committee and progress will be assessed and 3.1-19(b) adjusted as needed. K 0511 **NFPA 101** SS=F Utilities - Gas and Electric

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet

Page 69 of 86

PRINTED: 06/01/2022 FORM APPROVED

CV0021

Facility ID: 013420

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 05/10/2022 155831 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 **BRIARCLIFF HEALTH & REHABILITATION CENTER** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE Bldg. 01 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 K511 Based on observation and interview the facility K 0511 06/17/2022 failed to ensure that the emergency generator had What corrective actions will be a reliable source of fuel in accordance with the accomplished for those residents found to have affected by the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, deficient practice; 2010 Edition, 5.1. LSC section 9.1.3.1 states A letter from the natural gas emergency generators shall be installed, tested supplier supporting that the and maintained in accordance with NFPA 110, provider is a reliable source will Standard for Emergency and Standby Power be added to the updated Life Systems, 2010 Edition. Section 5.1.1 states the Safety binder. How the facility will identify other following energy sources shall be permitted to be used for the emergency power supply (EPS): resident having the potential to be (1) Liquid petroleum products at atmospheric affected by the same deficient practice and what corrective pressure (2) Liquefied petroleum gas (liquid or vapor action will be taken; withdrawal) Access to a letter of reliability (3) Natural or synthetic gas covers the entire facility and Exception: For Level 1 installations in locations alleviates the practice from where the probability of interruption of off-site affecting all residents. What measures will be put into fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full place or what systemic changes output of the EPSS to be delivered for the class will be made to ensure that the specified shall be required, with the provision for deficient practice does not recur: automatic transfer from the primary energy Maintenance staff will be trained on putting together and source to the alternate energy source. A.5.1.1 states examples of probability of keeping a life safety binder with interruption could include the following: readily viewable paper copies. earthquake, flood damage, or a demonstrated Life Safety book will be audited utility unreliability. This deficient practice could once a week × 3 months, once affect all residents. a month × 6 months, and

Findings include:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVO021

Facility ID: 013420

compliance.

If continuation sheet

quarterly afterwards to keep

Page 70 of 86

06/01/2022

PRINTED:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155831	B. WING		05/1	0/2022
NAME OF	PROVIDER OR SUPPLII		STREE	ET ADDRESS, CITY, STATE, ZIP COI	ЭE	
				WESTERN AVENUE		
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER	SOU	TH BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	,	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
				How will the corrective a		
		review and interview with the		monitored to ensure the		
		Fraining, Director of		practice will not recur, i.e		
		ntenance Assistant and		quality assurance progra	ms will	
		enance from another facility		be put into place;		
		een 9:45 a.m. and 12:15 p.m.,		Maintenance/designee		
		the emergency generator was		present 3 months of au		
	-	tionally, based on interview, the		results to QAPI commit		
		ve a letter from their natural		progress will be assess	ed and	
	e .	ating the natural gas was from a		adjusted as needed.		
	reliable source.					
	This finding was acknowledged by the					
	-	Fraining, Director of				
		Intenance Assistant and				
		enance from another facility at				
		ery and again at the exit				
		dministrator in Training,				
		enance, Maintenance Assistant,				
		ctor of Maintenance from				
		d Corporate Representative				
	present at 4:15 p.r					
	3.1-19(b)					
K 0711	NFPA 101					
SS=F	Evacuation and	Relocation Plan				
Bldg. 01	Evacuation and					
5. 2.		n plan for the protection of all				
		their evacuation in the event				
	of an emergency					
		periodically instructed and				
		th their duties under the				
		of the plan is readily				
		ephone operator or with				
		n addresses the basic				
		ed of staff per 18/19.7.2.1.2				
		all of the fire safety plan				
	components per	• •				
	1					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 05/10/2022 155831 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 **BRIARCLIFF HEALTH & REHABILITATION CENTER** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and K 0711 06/17/2022 K711 interview; the facility failed to provide a written What corrective actions will be plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a accomplished for those residents written health care occupancy fire safety plan found to have affected by the that shall provide for the following: deficient practice; The written fire safety plan (1) Use of alarms (2) Transmission of alarm to fire department provided in the EPP binder will (3) Emergency phone call to fire department contain a section to include (4) Response to alarms information regarding the (5) Isolation of fire relocation of wheeled carts (6) Evacuation of immediate area from hallways to designated (7) Evacuation of smoke compartment locations. (8) Preparation of floors and building for How the facility will identify other resident having the potential to be evacuation (9) Extinguishment of fire affected by the same deficient Section 19.2.3.4(4) Projections into the required practice and what corrective width shall be permitted for wheeled equipment, action will be taken; provided that all of the following conditions are By providing written direction, the whole facility should be met: (a) The wheeled equipment does not reduce the covered under this change (1). clear unobstructed corridor width to less than 60 What measures will be put into inches. place or what systemic changes (b) The health care occupancy fire safety plan will be made to ensure that the and training program address the relocation of deficient practice does not recur: the wheeled equipment during a fire or similar EPP binder will be audited once emergency. a week × 3 months, once a (c)The wheeled equipment is limited to the month × 6 months, and quarterly afterwards to following: i. Equipment in use and carts in use maintain compliance. How will the corrective action be ii. Medical emergency equipment not in use iii. Patient lift and transport equipment monitored to ensure the deficient This deficient practice could affect all practice will not recur, i.e. what occupants. quality assurance programs will be put into place; Maintenance/designee will Findings include:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CVO

CVOO21 Facility I

Facility ID: 013420

present 3 months of audit

If continuation sheet Pa

Page 72 of 86

PRINTED:

06/01/2022

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		01	r í	MPLETED	
		155831	B. WING		01		/10/2022	
		10001					10/2022	
NAME OF	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP COE	ЭE		
BRIARC	LIFF HEALTH & RE	HABILITATION CENTER			BEND, IN 46619			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	COMPLETIC	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	1	ΓAG	DEFICIENCY)		DATE	
	Based on records re	eview and interview with the			results to QAPI commit	tee and		
	Administrator in Training, Director of				progress will be assess	ed and		
	Maintenance, Main			adjusted as needed.				
	Director of Mainter							
	on 05/10/22 betwee							
	the written fire safe							
		on of wheeled equipment						
	during a fire or sim							
	Ũ	the facility tour, wheeled						
		was observed throughout the						
	building.							
	This finding was ac	knowledged by the						
	Administrator in Ti	raining, Director of						
	Maintenance, Main	tenance Assistant and						
	Director of Mainter	nance from another facility at						
	the time of discove	ry and again at the exit						
	conference with Ad	lministrator in Training,						
	Director of Mainter	nance, Maintenance Assistant,						
	an additional Direc	tor of Maintenance from						
	another facility and	Corporate Representative						
	present at 4:15 p.m							
	3.1-19(b)							
0712	NFPA 101							
SS=F	Fire Drills							
3ldg. 01	Fire Drills							
	Fire drills include	the transmission of a fire						
	alarm signal and	simulation of emergency						
		e drills are held at						
		expected times under						
		s, at least quarterly on each						
		amiliar with procedures						
		drills are part of established						
		rills are conducted between						
	9:00 PM and 6:00							
		ay be used instead of						
	audible alarms.							
	19.7.1.4 through '	19717						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	r í	JILDING	ONSTRUCTION <u>01</u>	(X3) DATE ( COMPL 05/10/	ETED
	PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619		00,10,	
BRIARC (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIT REGULATORY OF Based on record a facility failed to of documented orier 2 of 4 quarters. L be conducted qua familiarize facilit maintenance engin with the signals a under varied cond temporary waiven drill, a documenter related to the curr current facility con training will instr existing, new or t current duties, life protection device	REHABILITATION CENTER STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) review and interview, the conduct fire drills or ntation training on each shift for SC 19.7.1.6 states drills shall rterly on each shift to y personnel (nurses, interns, ineers, and administrative staff) nd emergency action required ditions. QSO-20-31 1135 r states in lieu of a physical fire ed orientation training program rent fire plan, which considers onditions, is acceptable. The uct employees, including emporary employees, on their e safety procedures and the fire s in their assigned area. This affects all staff and patients.	K 0	ID PREFIX TAG	H BEND, IN 46619  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  K712  What corrective actions will be accomplished for those reside found to have affected by the deficient practice; Fire drills or trainings will be documented and provided in updated Life Safety binder. Drills or trainings will be performed at least quarterly. How the facility will identify oth resident having the potential to affected by the same deficient practice and what corrective action will be taken; Fire drills or trainings shall b performed for all shifts. What measures will be put into	ents an her be	(X5) COMPLETION DATE 06/17/2022
	Administrator in Maintenance, Ma Director of Maint on 05/10/22 betw the following shift of a completed fin orientation trainir a) All shifts in the b) All shifts in the c) All shifts in the d) 2 of 3 shifts in Based on interviet the Administrator Maintenance agree missing fire drills	review and interview with the Training, Director of intenance Assistant and tenance from another facility een 9:45 a.m. and 12:15 p.m., fts were missing documentation re drill or documented			place or what systemic change will be made to ensure that the deficient practice does not rec Maintenance staff will be trained on putting together a keeping a life safety binder w readily viewable paper copie Life Safety book will be audit once a week × 3 months, ond a month × 6 months, and quarterly afterwards to keep compliance. How will the corrective action I monitored to ensure the deficie practice will not recur, i.e. wha quality assurance programs w be put into place; Maintenance/designee will present 3 months of audit results to QAPI committee an progress will be assessed an adjusted as needed.	e ur: nd vith s. ted ce be ent ill	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CVOO21 Facility ID: 013420

PRINTED: 06/01/2022 FORM APPROVED

If continuation sheet Page 74 of 86

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	CON	(X3) DATE SURVEY COMPLETED 05/10/2022		
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
< 0741 SS=E Bldg. 01	Administrator in T Maintenance, Mai Director of Mainte the time of discove conference with A Director of Mainte an additional Dire another facility an present at 4:15 p.m 3.1-19(b) 3.1-51(c) NFPA 101 Smoking Regula Smoking Regula Smoking Regula Smoking regulati shall include not provisions: (1) Smoking shal ward, or compart liquids, combusti or stored and in a location, and suc signs that read N posted with the in smoking. (2) In health care smoking is prohil prominently place secondary signs smoking shall no (3) Smoking by p responsible shall (4) The requirem apply where the supervision. (5) Ashtrays of n	tions tions ons shall be adopted and less than the following I be prohibited in any room, ment where flammable ble gases, or oxygen is used any other hazardous h area shall be posted with O SMOKING or shall be nternational symbol for no e occupancies where bited and signs are ed at all major entrances, with language that prohibits t be required. vatients classified as not						

STATEME	NT OF DEFICIENCIES	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155831	B. WING	<u> </u>	05/10/2022	
		100001				
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	E	
				VESTERN AVENUE		
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER	SOUTH	H BEND, IN 46619		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	LD BE COMPLET	ION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	where smoking is	s permitted.				
	(6) Metal contain	ers with self-closing cover				
	devices into whic	h ashtrays can be emptied				
	shall be readily a	vailable to all areas where				
	smoking is permi	tted.				
	18.7.4, 19.7.4					
		ion and interview; the facility	K 0741	K741	06/17/2	022
		of 1 smoking areas were		What corrective actions w		
	maintained by disp	posing cigarette butts in a metal		accomplished for those re	esidents	
		container with self-closing		found to have affected by	the	
		s deficient practice could		deficient practice;		
		r more residents in the		Designated smoking area will		
	smoking area.			be provided with a recept		
				of appropriate build in the	ne	
	Findings include:			designated location.		
				How the facility will identit	-	
		ion and interview during the		resident having the poten		
		he Administrator in Training,		affected by the same defi		
		mance, Maintenance Assistant		practice and what correct	ive	
		aintenance from another		action will be taken;		
		2 between 12:15 p.m. and		Education will be provid		
		) one designated smoking area		staff about use of recept		
		cigarette butts disposed on		and smoking only in des	-	
	-	around the smoking area.		location. Existing butts		
		mokers tower receptacle was		cleaned from areas.		
	-	ered no longer n the smoking		What measures will be pu		
		s near the smoking area were		place or what systemic ch will be made to ensure th	-	
	-	tts. Based on interview at the ns, the Executive Director		deficient practice does no		
		ere over 30 cigarette butts on		Education will be provid		
		forementioned location. Also,		staff regarding the use a		
	-	leading out of the basement to		importance of a designa		
		0 cigarette butts were		smoking area.		
		ound the entrance to the		How will the corrective ac	tion be	
		istant Maintenance Director		monitored to ensure the c		
		a was not a designated smoking		practice will not recur, i.e.		
		ty only had the one area		quality assurance program		
		f smoking and that residents at		be put into place;		
	the facility do not			Maintenance/designee v	vill	
	and mening do not		present 3 months of audit			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet Page 76 of 86

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	( <b>V</b> 2) MUU 7	TIDI E CO	INSTRUCTION		MB NO. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL				PLETED
AND PLAN	OF CORRECTION		B. WINC		01		
		155831				05/10	0/2022
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER			BEND, IN 46619		1
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF	PRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		ГАG	DEFICIENCY)		DATE
	-	cknowledged by the			results to QAPI committee		
		raining, Director of			progress will be assessed	and	
		ntenance Assistant and			adjusted as needed.		
		nance from another facility at					
		ery and again at the exit					
		dministrator in Training,					
		nance, Maintenance Assistant,					
		tor of Maintenance from					
	-	l Corporate Representative					
	present at 4:15 p.m	l.					
	3.1-19(b)						
<b>&lt;</b> 0781	NFPA 101						
SS=E	Portable Space H	leaters					
Bldg. 01	Portable Space H	leaters					
	Portable space h						
	prohibited in all h	ealth care occupancies,					
		ed in nonsleeping staff and					
		where the heating elements					
		2 degrees Fahrenheit (100					
	degrees Celsius)						
	18.7.8, 19.7.8						
		on and interview, the facility	K 078	1			06/17/202
		of 1 portable space heaters			K781		
		e facility. This deficient			What corrective actions will		
	practice could affe	ct up to 40 residents.			accomplished for those resi		
	F' 1' ' 1 1				found to have affected by the	ie	
	Findings include:				deficient practice;		
	Decedent sheemed	an and interminent dening the			Identified electric fireplace		
		on and interview during the ne Administrator in Training,			be disconnected and cut of		
		nance, Maintenance Assistant			from power and cut from t plugged in.	being	
		intenance from another			How the facility will identify	othor	
		2 between 12:15 p.m. and			resident having the potentia		
		le space heater was in use in			affected by the same deficie		
		rea. The free standing electric			practice and what corrective		
		pped with a thermostat and			action will be taken;		
		ced heat. Based on interview at			All identified space heater	s will	
		ervations, the Assistant			be disconnected (with no	5 WIII	
	and time of the obs	ervations, the Assistant					1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/10/2022		
	PROVIDER OR SUPPLIE	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DATE		
	being used in a resheat. This finding was a Administrator in T Maintenance, Mai Director of Mainten the time of discove conference with A Director of Mainten an additional Dire	ctor agreed a space heater was sident care area and produced acknowledged by the Training, Director of Intenance Assistant and enance from another facility at ery and again at the exit dministrator in Training, enance, Maintenance Assistant, ctor of Maintenance from d Corporate Representative n.		plug-in) or taken off the f premises. What measures will be put place or what systemic cha will be made to ensure tha deficient practice does not Maintenance will check fa for space heaters quarter maintain compliance. How will the corrective act monitored to ensure the de practice will not recur, i.e. quality assurance program be put into place; Maintenance/designee wi present 3 months of audi results to QAPI committee progress will be assessed adjusted as needed.	t into anges t the recur: acility ty to ion be eficient what as will iII t t e and		
K 0918 SS=F Bldg. 01	Electrical System System Maintena The generator of source and asso of supplying served 10-second criterin monthly test, a p annually confirm safety and critical and testing of the switches are per NFPA 110. Generator sets and exercised under year in 20-40 date once every 36 m hours. Scheduler	hs - Essential Electric Syste hs - Essential Electric ance and Testing r other alternate power ciated equipment is capable rice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life Il branches. Maintenance e generator and transfer formed in accordance with re inspected weekly, load 30 minutes 12 times a y intervals, and exercised onths for 4 continuous d test under load conditions re simulated cold start and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED	
AND TEAN OF CORRECTION	155831	B. WING	<u>01</u>	05/10/2022	
NAME OF PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP CODE		
BRIARCLIFF HEALTH & R	EHABILITATION CENTER		VESTERN AVENUE H BEND, IN 46619		
	STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE	
loads, and are compersonnel. Maintenergy power solution accordance with circuit breakers at a program for personnents is even and for a separate from a separate from and separate from and separate from Minimizing the premergency power consideration for 6.4.4, 6.5.4, 6.6. NFPA 111, 700. I Based on record facility failed to main record of monthly the last 12 monthes 2012 NFPA 99 regenerator serving system to be in a constandard for Emergine Systems, Chapter diesel generator serving serving and for Emergination for the facility failed to main the facility failed to main the facility for the serving system to be in a constant for the serving system to be in a constant for Emergination for the serving serving for the serving system to be in a constant for Emergination for the facility failed to the regularity main the facility. Findings include:	nual transfer of all EES onducted by competent cenance and testing of stored purces (Type 3 EES) are in NFPA 111. Main and feeder are inspected annually, and riodically exercising the stablished according to quirements. Written records and testing are maintained able. EES electrical panels marked, readily identifiable, m normal power circuits. ossibility of damage of the er source is a design new installations. 4 (NFPA 99), NFPA 110, 10 (NFPA 70) review and interview, the maintain a complete written generator load testing for 9 of c. Chapter 6.4.4.1.1.4(a) of quires monthly testing of the the emergency electrical cordance with NFPA 110, the regency and Standby Powers 8. NFPA 110 8.4.2 requires ets in service to be exercised at y, for a minimum of 30 6.4.4.2 of NFPA 99 requires a nspection, performance, and repairs for the generator intained and available for authority having jurisdiction. ctice could affect all residents	K 0918	K918 What corrective actions will be accomplished for those resident found to have affected by the deficient practice; Monthly generator load tests and emergency battery-powered lamps will be completed and documented monthly in an updated Life Safety binder for review. How the facility will identify othe resident having the potential to affected by the same deficient practice and what corrective action will be taken; Monthly tests will utilize the generator which functions for the whole facility. What measures will be put into place or what systemic changes will be made to ensure that the	r be	

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

IDENTIFICATION NUMBER:

155831

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY A. BUILDING COMPLETED 01 B. WING 05/10/2022

## STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETIC DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION)Administrator in Training, Director of Maintenance, Maintenance Assistant and Director of Maintenance from another facility on 05/10/22 between 9:45 a.m. and 12:15 p.m., only November and December of 2021 and January of 2022 documentation was provided to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Records for the remaining months were missing. The Maintenance Director attempted to locate the records in the TELS program, but not documentation or visual confirmation was provided during the survey. This finding was acknowledged by the Administrator in Training, Director of Maintenance, Maintenance from another facility at the time of discovery and again at the exit conference with Administrator in Training, Director of Maintenance, Maintenance from an additional Director of Maintenance from another facility and Corporate Representative present at 4:15 p.m.2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) deficient practice does not recur: Maintenance staff will be trained on putting together and keeping a life safety binder with readily viewable paper copies. Life Safety book will be audited once a week × 3 months, once a month × 6 months, and quarterly afterwards to keep compliance. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place; Maintenance/designee will present 3 months of audit results to QAPI committee and progress will be assessed and adjusted as needed	
	generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery			

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CON	STRUCTION	(X3) DAT	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	01	COM	PLETED	
		155831	B. WING					
			ST	STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF	PROVIDER OR SUPPLIE	ER			STERN AVENUE			
BRIARC	LIFF HEALTH & R	EHABILITATION CENTER			BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID				(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	D BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE	
	powered and (5) V	Vritten records of visual						
	•	sts shall be kept by the owner						
	-	he authority having						
		deficient practice could affect						
	all residents in the							
	Findings include:							
	Based on records	review and interview with the						
	Administrator in T	raining, Director of						
	Maintenance, Mai	ntenance Assistant and						
	Director of Mainte	enance from another facility						
	on 05/10/22 betwee	en 9:45 a.m. and 12:15 p.m.,						
	no documentation	was available for review to						
	show the emergen	cy battery powered light at the						
	generator was test	ed monthly for a minimum of						
	30 seconds or ann	ually for 90 minutes.						
	-	cknowledged by the						
		Fraining, Director of						
		ntenance Assistant and						
	Director of Mainte	enance from another facility at						
	the time of discov	ery and again at the exit						
	conference with A	dministrator in Training,						
	Director of Mainte	enance, Maintenance Assistant,						
	an additional Dire	ctor of Maintenance from						
	another facility an	d Corporate Representative						
	present at 4:15 p.n	n.						
	3.1-19(b)							
K 0920	NFPA 101							
SS=E		nent - Power Cords and						
Bldg. 01	Extens							
-	Electrical Equipn Extension Cords	nent - Power Cords and						
		patient care vicinity are						
		nponents of movable						
		ted electrical equipment						
		bles that have been						
	1, , , , , ,							

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION (1	X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155831	A. BUILDING B. WING	<u>01</u>	completed 05/10/2022
IAME OF	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
AME OF	FRO VIDER OR SUFFEIE	κ.	5024 V	VESTERN AVENUE	
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER	SOUTH	H BEND, IN 46619	
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE
		alified personnel and meet			
		10.2.3.6. Power strips in			
		icinity may not be used for			
		, personal electronics),			
		m care resident rooms that			
		E. Power strips for PCREE			
		or UL 60601-1. Power strips			
		the patient care rooms			
	· ·	y) meet UL 1363. In			
		rooms, power strips meet ds.  All power strips are			
		I precautions. Extension			
	-	d as a substitute for fixed			
	wiring of a structure. Extension cords used temporarily are removed immediately upon				
		purpose for which it was			
		ets the conditions of 10.2.4.			
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99),			
		, 590.3(D) (NFPA 70), TIA			
	12-5				
	1. Based on observ	ation and interview, the	K 0920	K920	06/17/202
	facility failed to en	sure all rooms did not used		What corrective actions will be	
		s as a substitute for fixed		accomplished for those residen	ts
	-	requires electrical wiring and		found to have affected by the	
		in accordance with NFPA 70,		deficient practice;	
		Code. NFPA 70, 2011		Multi-plug adapters, and powe	er
		0.8 requires that, unless		strips will be removed,	
		ted, flexible cords and cables		corrected, and substituted for	а
		s a substitute for fixed wiring		viable, compliant, alternative.	Ar .
	of a structure. This staff.	deficient practice affects 3		How the facility will identify othe resident having the potential to	
	stall.			affected by the same deficient	
	Findings include:			practice and what corrective	
	i munigs menude.			action will be taken;	
	Based on observati	on and interview during the		The facility will be toured in its	s
		ne Administrator in Training,		entirety to check for these	-
	-	nance, Maintenance Assistant		occurrences.	
		intenance from another		What measures will be put into	
		2 between 12:15 p.m. and		place or what systemic changes	6
		ntenance office in the	1	will be made to ensure that the	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/10/2022
	NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER			TADDRESS, CITY, STATE, ZIP COD WESTERN AVENUE TH BEND, IN 46619	E
BRIARC (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C basement containe powering comput equipment behind This finding was a Administrator in 7 Maintenance, Ma Director of Maint the time of discov conference with A Director of Maint an additional Dire another facility ar present at 4:15 p.n 2. Based on obser facility failed to e not used as a subs provide power eq draw. NFPA-70/2 specifically permi and cables shall n substitute for fixe practice could aff staff. Findings include:	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) ed a multi-plug adaptor ers and other electrical I the desk acknowledged by the Training, Director of intenance Assistant and enance from another facility at very and again at the exit administrator in Training, enance, Maintenance Assistant, ector of Maintenance from ad Corporate Representative			LD BE ROPRIATE     COMPLETIO DATE       t recur:     igned a       igned a     ove and       s of     rill be       with     options       and     re on       ed on     ion of       ction be     deficient       . what     ms will       vill     dit
	facility tour with t Director of Maint and Director of M facility on 05/10/2 3:10 p.m., (1) in t strip was being us refrigerator (high (2) in the Busines cords were being	the Administrator in Training, enance, Maintenance Assistant laintenance from another 22 between 12:15 p.m. and the Restorative Office a power sed to power door style power draw equipment). And s office two green extension used to power a microwave and rator (high power draw			

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STATEME	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	ì í	JILDING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED <b>05/10/2022</b>		
NAME OF	PROVIDER OR SUPPLIE	R		5024 W	ADDRESS, CITY, STATE, ZIP CODE /ESTERN AVENUE			
BRIARC	LIFF HEALTH & RI	EHABILITATION CENTER		SOUTH	I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	APPROPRIATE DATE		
	Administrator in T Maintenance, Main Director of Mainte the time of discove conference with A Director of Mainte an additional Direct	cknowledged by the raining, Director of ntenance Assistant and nance from another facility at ery and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative n.						
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen of containers over 5 conditions under Transfilling to liqu portable container conditions under 11.5.2.2 (NFPA 9 1. Based on record	Transfilling Cylinders Transfilling Cylinders ygen from one cylinder to ordance with CGA P-2.5, th Pressure Gaseous Respiration. Transfilling of e cylinder to another is ent care rooms. Transfilling containers or to portable to psi comply with 11.5.2.3.1 (NFPA 99). did oxygen containers or to ors under 50 psi comply with 11.5.2.3.2 (NFPA 99). 99) s review and interview, the asure staff was properly	К 0	927	<b>K927</b> What corrective actions wil	I be	06/17/202	
	trained on trans-fil oxygen storage roo takes place. NFP (4) the individual t has been properly	ling procedures in 1 of 1 om where oxygen transferring A 99 2012 edition, 11.5.2.3.1 rans-filling the container(s) trained in the trans-filling eficient practice could affect			accomplished for those res found to have affected by t deficient practice; A light fixture will be prov to the O2 transfilling stati room, an "in-use" slider v mounted and provided ne station, and the room will	idents he ided on vill be ear the		

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155831 B. WING 05/10/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Findings include: adjusted such that there is ample space to stand in the Based on records review and interview with the room. How the facility will identify other Administrator in Training, Director of resident having the potential to be Maintenance, Maintenance Assistant and Director of Maintenance from another facility affected by the same deficient practice and what corrective on 05/10/22 between 9:45 a.m. and 12:15 p.m., action will be taken; no documentation was available for review to indicate staff that trans-fill liquid oxygen were Proper O2 transfilling training will be provided to current staff properly trained. and will be supplied to new staff during orientation. This finding was acknowledged by the Administrator in Training, Director of Documentation of training will Maintenance, Maintenance Assistant and be included in orientation process. Director of Maintenance from another facility at the time of discovery and again at the exit What measures will be put into conference with Administrator in Training, place or what systemic changes Director of Maintenance, Maintenance Assistant, will be made to ensure that the an additional Director of Maintenance from deficient practice does not recur: another facility and Corporate Representative DON/designee will educate all present at 4:15 p.m. relevant nursing personnel on proper transfilling procedures. 2. Based on observation and interview, the Maintenance/designee will facility failed to ensure 1 of 1 oxygen interview at least 3 staff transfilling rooms had lighting. NFPA 99, Health members per week until Care Facilities Code, 2012 edition, Section compliance has been met for at least one month. 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, is sprinklered, and How will the corrective action be monitored to ensure the deficient have ceramic or concrete flooring. This deficient practice could affect 30. practice will not recur, i.e. what quality assurance programs will be put into place; Findings include: Maintenance/designee will present 3 months of audit Based on observation and interview during the facility tour with the Administrator in Training, results to QAPI committee and Director of Maintenance, Maintenance Assistant progress will be assessed and and Director of Maintenance from another adjusted as needed. facility on 05/10/22 between 12:15 p.m. and 3:10 p.m., the oxygen storage/transfilling room did not have any lighting source, making it

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C

CVOO21 Facility ID:

Facility ID: 013420

If continuation sheet

Page 85 of 86

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NTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155831	(X2) MULTIPLE CC A. BUILDING B. WING	01		(X3) DATE SURVEY COMPLETED 05/10/2022	
NAME OF PROVIDER OR SUPPLIER BRIARCLIFF HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRC DEFICIENCY)	BE	(X5) COMPLETION DATE	
	when asked to dem transferred, stood w with her foot to sim when asked if this facility preform this This finding was an Administrator in T Maintenance, Main Director of Mainte the time of discove conference with Ad Director of Mainte an additional Direct	position. The available QMA, nonstrate how oxygen was with the door propped open nulate the process. The QMA is how most people in the is procedure stated, yes. cknowledged by the raining, Director of ntenance Assistant and nance from another facility at ery and again at the exit dministrator in Training, nance, Maintenance Assistant, etor of Maintenance from d Corporate Representative the					

CVOO21 Facility ID: 013420

3420 If continua

If continuation sheet Page 86 of 86

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06/01/2022