STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	**5024 WESTERN AVENUE SOUTH BEND, IN 46619**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00357698 and IN00356509. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and a PSR to the Investigation of Complaint IN00352288 completed on 5/28/21.

Complaint IN00357698 - Unsubstantiated due to lack of evidence.

Complaint IN00356509 - Unsubstantiated due to lack of evidence.

Complaint IN00352288 - Corrected.

Survey dates: 7/15/21

Facility number: 013420
Provider number: 155831
AIM number: 201293620

Census Bed Type:
SNF/NF: 56
Total: 56

Census Payor Type:
Medicare: 3
Medicaid: 42
Other: 11
Total: 56

Briarcliff Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00357698 and IN00356509.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	**5024 WESTERN AVENUE SOUTH BEND, IN 46619**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Quality review completed on 7/16/21.	F 000		