STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 3, 4, 5, 6, 7, 8 and 9, 2024 Facility number: 000246 Provider number: 155355 AIM number: 100275420 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 8 Medicaid: 37 Other: 12 Total: 57 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 12/17/2024	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The facility is requesting a desk review in lieu of post survey revisit on or after 1/14/2025.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to provide a copy of the Notice of Transfer/Discharge form when residents were transferred and admitted to an acute care facility for 2 of 2 residents reviewed for hospitalization. (Residents 4 and 16) Findings include: 1. A record review was completed on 10/3/2024 at	F 0623	The facility requests a face to face IDR for F623. The facility disagrees with the scope and severity cited for F623. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	01/13/2025

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

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	2:10 P.M. for Resident 4. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, respiratory failure and heart failure. A Significant Change Minimum Data Set (MDS) assessment, dated 10/23/2024, indicated Resident 4's cognition was intact. On 10/5/2024 at 6:15 P.M., Nursing Progress notes indicated Resident 4 was found unresponsive. After an assessment and notification to the physician, Resident 4 was sent to the emergency room. Her husband was notified by phone of the transfer but the record lacked documentation that the Notification of Transfer/Discharge form was provided to the resident or her husband. During an interview on 12/05/24 at 2:16 P.M., the ED indicated there was no documentation of the transfer paperwork, including the Transfer/Discharge form for Resident 4.2. During an interview on 11/3/2024 at 10:31 A.M., Resident 16 indicated she had been to the hospital in the last four months. A Nursing Progress note, dated 9/19/2024 at 6:30 P.M., indicated Resident 16 was sent to the Emergency Department (ER) due to lower back pain and vomiting. A Nursing Progress note, dated 9/19/2024 at 7:49 P.M., indicated the Director of Nursing, Resident 16's family and the Primary Care Physician had been notified of the resident's transfer to the ER. A Nursing Progress note, dated 9/20/2024 at 6:25 A.M., indicated Resident 16 was admitted to the hospital. A Nursing Progress note, dated 10/4/2024 at 7:48		The facility is unable to correct deficient practice for Resident 4 due to transfer occurring in October 2024 and Resident 16 transfer occurring in September 2024. Nurses will be reeducated on Hospital/Discharge Transfer Policy by January 13, 2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who have been transferred to acute care setting in the past have the potential to be affected by the same deficient practice, due to the occurrence happening in the past deficient practice for those residents are not able to be corrected. Any resident transferred within the last 15 days will have the Notice of Transfer/Discharge form will be provided to the resident and mailed to the resident representative. To correct the action for future transfers/discharges nurses will be reeducated on the Hospital/Discharge Transfer Policy. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses will be reeducated on Hospital/Discharge Transfer Policy	

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	P.M., indicated Resident 16's family was concerned about the resident's health and requested the resident be sent to the hospital for evaluation. A Nursing Progress note, dated 10/4/2024 at 8:00 P.M., indicated after assessing the resident, the nurse called Emergency Services and the resident had been transported to the hospital. The record lacked the documentation that a transfer/discharge assessment and forms had been completed in conjunction with Resident 16's transfer to the hospital on 9/20/2024 and 10/4/2024. During an interview on 12/5/2024 at 2:16 P.M., the Administrator (ED) indicated the record lacked copies of transfer paperwork, which included the notice of transfer and bed hold policy paperwork. On 12/5/2024 a policy was requested regarding documentation of a transfer/discharge assessment and one was not provided prior to the survey exit. 3.1-12(a)(6)(A)		by January 13, 2025. DNS/designee will review nursing documentation daily Monday through Friday for hospital/discharge transfers. IDT will complete the IDT transfer review tool with each transfer/discharge to ensure notice of transfer/discharge form is provided to the resident and resident representative. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Ed/designee will be responsible for completing the QAPI Audit Tool "Transfer/Discharges/Bed Hold" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up. **By what date the systemic changes will be completed:** January 14, 2025	
F 0625 SS=D	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr			

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Bldg. 00	Based on interview and record review, the facility failed to provide a copy of the Bed Hold Policy to residents when admitted to the hospital for 2 of 2 residents reviewed for hospitalization. (Residents 4 and 16) Findings include: 1. A record review was completed on 10/3/2024 at 2:10 P.M. for Resident 4. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, respiratory failure and heart failure. A Significant Change Minimum Data Set (MDS) assessment, dated 10/23/2024, indicated Resident 4's cognition was intact. On 10/5/2024 at 6:15 P.M., Nursing Progress Notes indicated Resident 4 was found unresponsive. After an assessment and notification to the physician, Resident 4 was sent to the emergency room. Her husband was notified by phone of the transfer but the record lacked documentation that the Bed Hold Policy was provided to the resident or her husband. During an interview on 12/05/24 at 2:16 P.M., the ED indicated there was no documentation of the transfer paperwork, including the Transfer/Discharge form for Resident 4.2. During an interview on 11/3/2024 at 10:31 A.M., Resident 16 indicated she had been to the hospital in the last four months and did not recall receiving a bed hold policy. A Nursing Progress note, dated 9/19/2024 at 6:30 P.M., indicated Resident 16 was sent to the Emergency Department (ER) due to lower back pain and vomiting.	F 0625	The facility requests a face to face IDR for F625. The facility disagrees with the scope and severity cited for F625. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The facility is unable to correct deficient practice for Resident 4 due to transfer occurring in October 2024 and Resident 16 transfer occurring in September 2024. Nurses will be reeducated on Bed Hold Policy by January 13, 2025 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who have been transferred to acute care hospital in the past have the potential to be affected by the same deficient practice, due to the occurrence happening in the past deficient practice for those residents are not able to be corrected. Any resident transferred within the last 15 days will have the bed hold policy provided to the resident and mailed to the resident representative. To correct the action for future temporary transfers/discharges nurses will be	01/13/2025

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	A Nursing Progress note, dated 9/19/2024 at 7:49 P.M., indicated the Director of Nursing, Resident 16's family and Primary Care Physician were notified the resident was being transferred to the ER. A Nursing Progress note, dated 9/20/2024 at 6:25 A.M., indicated Resident 16 was admitted to the hospital. A Nursing Progress note, dated 10/4/2024 at 7:48 P.M., indicated Resident 16's family was concerned about the resident's health and requested the resident be sent to the hospital for evaluation. A Nursing Progress note, dated 10/4/2024 at 8:00 P.M., indicated after assessing the resident, the nurse called Emergency Services and the resident was transported to the hospital. The record lacked the documentation that a bed hold policy was provided to the resident in conjunction with Resident 16's transfer to the hospital on 9/20/2024 and 10/4/2024. During an interview on 12/5/2024 at 2:16 P.M., the Administrator (ED) indicated the record lacked copies of transfer paperwork, which included the notice of transfer and bed hold policy paperwork. On 12/5/2024 at 2:30 P.M., the ED provided the policy titled, "Bed Hold Policy", dated 11/2017 and indicated it was the policy currently being used by the facility. The policy indicated "Purpose of Policy: Provide guidance to facility staff for holding a bed for a resident transfer. 2. The residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic		reeducated on the Bed Hold Policy. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses will be reeducated on Bed Hold Policy by January 13, 2025. DNS/designee will review nursing documentation daily Monday through Friday for transfers requiring Bed Hold and ensure the bed hold policy is provided to the resident and resident representative. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Ed/designee will be responsible for completing the QAPI Audit Tool "Transfer/Discharges/Bed Hold" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up. **By what date the systemic**	

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	leave. 4. The facility staff will document the notification to the resident and resident representative of the bed hold policy on the Emergency Resident Transfer Form ...." 3.1-12(25)(A)(B)		**changes will be completed:** January 14, 2025	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to have Care Plan meetings with residents and/or their representatives timely for 2 of 3 residents whose Care Plan meetings were reviewed. (Residents 47 & 38) Findings include: 1. During an interview on 12/03/2024 at 2:13 P.M., Resident 47 indicated he had not been to a Care Plan meeting with the staff. Resident 47's record review was completed on 12/4/2024 at 1:23 P.M. Resident 46 had a Minimum Data Set (MDS) assessment completed on the following dates: -11/19/2024 Quarterly MDS assessment -8/21/2024 Significant Change MDS assessment -5/31/2024 Quarterly MDS assessment -5/14/2024 Quarterly MDS assessment -3/19/2024 Annual MDS assessment -1/2/2024 Quarterly MDS assessment There was no documentation a Care Plan meeting with Resident 47 had been conducted following any of the MDS assessments, except after the 2/18/2024 Annual MDS assessment. During an interview on 12/5/2024 at 2:34 P.M., the	F 0657	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #38 and #47 was offered a care plan meeting with IDT. Care plan meeting occurred with resident, and/or responsible party. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All other residents have the potential to be affected. All current residents were audited to ensure a care plan meeting was held within the last 90 days **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** Social Services Director and Memory Care Support Specialist will be reeducated regarding the expectation of quarterly care plan meetings. All residents in their MDS assessment period will be	01/13/2025

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	Social Services Director indicated she had met with Resident 47 regularly, but had not had a Care Plan meeting with him following his MDS assessments. During an interview on 12/6/2024 at 8:45 A.M., the Executive Director indicated Resident 47 had not received Care Plan meetings regularly after his MDS assessments. 2. During an interview on 12/4/2024 at 10:45 A.M., Resident 38 indicated she had not met with staff about her care plan in a long time. A record review was completed on 10/5/2024 at 2:30 P.M. for Resident 38. Diagnoses included, but were not limited to, hypertension, general anxiety disorder and depression. An Annual Minimum Data Set (MDS) assessment, dated 11/6/2024, indicated Resident 38's cognition was intact. Resident 38's record lacked the documentation a Care Plan meeting had been conducted on a quarterly basis with Resident 38 and/or her representative from 6/6/2024 through 12/5/2024. During an interview on 12/05/24 at 2:45 P.M., the Social Service Director (SSD) indicated that she had not held any formal care plan meetings with Resident 38 and should have had them after quarterly assessments were completed on 8/14/2024 and on 11/6/2024. On 12/5/2024 at 3:00 P.M. a current policy, dated 8/2023, and titled, "IDT Comprehensive Care Plan Policy" was provided by the SSD. The policy indicated, "...During the meeting all IDT members promptly meet with resident and/or representative		discussed daily to ensure a quarterly care plan meeting has been scheduled. Social Services and Memory Care Support Specialist will implement a tracking log for all residents with the date of quarterly care plan meeting held, logs to be turned into ED weekly to ensure residents are invited to a quarterly care plan meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Ed/designee will be responsible for completing the QAPI Audit Tool “IDT Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up. **By what date the systemic changes will be completed:** January 14, 2025	

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	at the bedside, or resident's desired location, at the time mutually agreed upon by SS, IDT, resident and/or representative...." 3.1-(d)(2)(B)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on observation, interview and record review, the facility failed to 1 of 1 staff (LPN 2) met professional standards regarding signing off dressing changes for 1 of 3 residents reviewed for wounds. (Resident 42) Finding includes: During an observation and interview on 12/3/2024 at 9:41 A.M., Resident 42 indicated that she was supposed to get her dressing changed daily, and it had not been completed for two days. She had asked the evening shift to do it, but no one had completed her dressing change. The dressing covering the resident's left above the knee amputation revision wound was dated 11/30/2024. When Resident 42 pulled back the dressing, there was a large amount of reddish- brown thick drainage, an opening in the center of wound and erythema around the whole surgical site. During an observation and interview on 12/3/2024 at 10:12 A.M., LPN 2 indicated the dressing to the left leg was ordered to be changed daily, but the current dressing was dated 11/30, 4 days prior. LPN 2 indicated Resident 42 had went out of the building with a friend on 12/1/2024 and 12/2/2024 and had requested the dressing change to be completed later in the day, when she returned from her outings.	F 0658	It is the practice of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice at all times. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 42 was discharged 12/4/24 and has not readmitted to facility. LPN#2 was immediately educated by Clinical Educator. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. An audit of all residents who have orders for dressing change will be completed. Any findings will be reviewed and resident/POA, MD/NP will be notified immediately. **What measures will be put in place or what systemic changes will be made to**	01/13/2025

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	A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. A Physician Order, dated 11/27/2024 indicated the following: - left surgical above the knee wound to cleanse with wound wash, dry, apply skin prep then xeroform to wound bed and cover with an abdominal dressing and wrap with kerlix dressing. A Current Care Plan, dated 10/30/2024, indicated impaired skin integrity related to a surgical wound, with the following intervention of treatment as ordered. A Treatment Administration Record, for December, dated 12/1/2024 - 12/4/2024, indicated the dressing was documented as changed on 12/1/2024 and 12/2/2024. During an interview on 12/4/2024 at 3:18 P.M., LPN 2 indicated she had not changed Resident 42's dressing and the dressing changes should not have been signed off as completed on the TAR for 12/1/2024 and 12/2/2024. On 12/4/2024 at 3:40 P.M., a policy was requested but one was not provided. 3.1-50(a)(2)		**ensure that the deficient practice does not recur:** Nurses will be reeducated on professional standards of practice for dressing changes. DNS/Designee will round daily Monday through Friday to ensure dressings are changed per MD order and per protocol. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit Tool “Professional standards of practice for dressing changes” 3 x a week for 4 weeks, weekly x 4 weeks, monthly for 6 months and **By what date the systemic changes will be completed:** January 14, 2025	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, facility failed to ensure a resident received a treatment per the physician order for 1 of 3 resident's reviewed for skin condition. (Resident 42) Finding includes: During an observation and interview, on 12/3/2024 at 9:41 A.M., Resident 42 indiated she was supposed to have gotten her dressing changed daily, but it had not been done for the past two days. She indicated she had requested the evening shift staff to complete it, but no one had came to change the dressing. The dressing on her left above the knee amputation site was dated 11/30/2024. The dressing was loose and a large amount of reddish-brown thick drainage was noted when the resident pulled back the edge of the dressing, the center of the wound had an opened area and the tissue around the wound and incision was red. A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. A Current Care Plan, dated 10/30/2024, indicated impaired skin integrity related to a surgical wound,	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 42 was discharged 12/4/24 and has not readmitted to facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with wounds have the potential to be affected. An audit of all residents who have orders for dressing change will be completed. Any findings will be reviewed and resident/POA, MD/NP will be notified immediately. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses will be reeducated on following physician orders, signing treatment off and information to be provided to each other in shift-to-shift reporting. DNS/Designee will round Monday through Friday for residents with wounds to ensure MD orders are followed and documented appropriately.	01/13/2025

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	with the following intervention of treatment as ordered. A Physician Order, dated 11/27/2024 indicated the following: -left surgical above the knee wound to cleanse with wound wash, dry, apply skin prep then xeroform to wound bed and cover with an abdominal dressing and wrap with kerlix dressing. During an observation and interview on 12/3/2024 at 10:12 A.M., LPN 2 indicated the dressing to the left leg was ordered daily but the current dressing was dated 11/30., four day prior LPN 2 indiated Resident 42 went out with a friend during the day, on 12/1/2024 and 12/2/2024, and requested the dressing changes be completed when she had returned from her outings. During an interview on 12/4/2024 at 3:18 P.M., LPN 2 indicated she had not passed on in report to the evening shift that Resident 42 needed her dressing change completed when she returned from her leave of absence on 12/1/2024 and 12/2/2024. The dressing was not changed, even though the TAR (Treatment Record) had been inaccurately signed as completed on 12/1/2024 and 12/2/2024. A Nursing Progress note, dated 12/1/2024 at 1:15 P.M., indicated Resident 42 had requested her dressing to remain in place as she was going out of the building with a friend.. On 12/5/2024 at 8:53 A.M., the DON indicated that they did not have a policy on following physician orders was just the "standard of practice." 3.1-37(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit Tool “Professional standards of practice for dressing changes” 3 x a week for 4 weeks, weekly x 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up. **By what date the systemic changes will be completed:** January 14, 2025	

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	155355	A. BUILDING 00 B. WING	12/09/2024

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on interview and record review, the facility failed to ensure residents were free from antibiotic medication used for an excessive duration for 1 of 6 residents reviewed for unnecessary medications. (Resident 41) Finding includes: A record review was completed on 12/5/2024 at 10:00 A.M. for Resident 41. Diagnoses included but were not limited to: acute osteomyelitis of left ankle and foot and stage 2 pressure ulcer on left heel. An Admission Minimum Data Set (MDS) assessment, dated 10/7/2024, indicated Resident 41's cognition was intact and he received antibiotic medication. Current Physician Orders included, but were not limited to, cephalexin (an antibiotic) ordered on 11/28/2024, 500 milligrams by mouth every 8 hours for a urinary tract infection. The antibotic was to have been completed and discontinued on 12/4/2024. A lab report, dated 11/30/2024, indicated a urine specimen showed no bacterial growth as the final result. The facility did not notify the Nurse Practioner, on 11/30/2024 of the need to discontinue the antibiotic treatment. An Event note, dated 12/5/2024, indicated the antibiotic was discontinued by the Nurse Practitioner due to no growth in the resident's urine, 5 days after the lab result was received.	F 0757	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 41 antibiotic was discontinued per order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving antibiotics have the potential to be affected by the same deficient practice. All residents receiving antibiotics will be audited to determine appropriateness, MD/NP will be notified as necessary. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses/MD/NP will be reeducated on Antibiotic Stewardship Program by January 13, 2025. IP nurse will review Facility Activity Report daily and follow up for appropriateness of antibiotic usage, any concern identified the MD will be notified. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	01/13/2025

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	During an interview on 12/6/2024 at 1:14 P.M., the Infection Preventionist indicated it was normal to stop antibiotics due to the lab results from 11/30/2024. On 12/3/2024 at 1:00 P.M. a current policy, dated January 2023 and titled, "Antibiotic Stewardship Program" was provided by the Executive Director. The policy indicated, " ...The facility shall establish key elements for antibiotic prescribing and a system to monitor and manage antibiotic use ...." 3.1-48(a)(2)		Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit Tool “Antibiotic Therapy” 3 x a week for 4 weeks, weekly x 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up. **By what date the systemic changes will be completed:** January 14, 2025	
F 0807 SS=D Bldg. 00	483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration Based on observation, interview and record review, the facility failed to ensure a resident received fresh ice water per his preference for 1 of 3 residents reviewed for hydration. (Resident 21) Finding includes: During an observation and interview, on 12/4/2024 at 12:05 P.M., Resident 21 indicated he had did not have fresh ice water delivered daily to his room. He indicated he desired to have fresh ice water in his room. He indicated the last date he had water delivered was on 11/13 and 11/29. During an observation and interview, on 12/4/2025	F 0807	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 21 has been provided with fresh ice water. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. All residents will be provided with fresh ice water every	01/13/2025

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	at 1:16 P.M., Resident 21 indicated staff did not pass water and he had to go to the nurse's station and to ask for it in order to have a drink of water. During an observation on 12/5/2025 at 9:42 A.M., there was no cup of water in Resident 21's room. A record review was completed on 12/4/2024 at 2:11 P.M., for Resident 21. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following nontraumatic intracerebral hemmorrhage affecting left dominant side, type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 9/26/2024, indicated resident required set up assistance for eating and had upper and lower body range of motion impairment to one side of his body. A Quarterly Hydration Review assessment, dated 11/11/2024, indicated Resident 21 required assistance with food and fluids. A current Care Plan, dated 6/26/2024, indicated Resident 21 required assistance or monitoring of nutrition, hydration and elimination. The plan did not address the resident's desire to have fresh ice water in his room. During an interview on 12/5/2024 at 9:43 A.M., CNA 11 indicated she only provided water to residents' that wanted it and she did not just leave water in resident's rooms for them. She indicated that Resident 21 could do things for himself. On 12/9/2024 at 10:00 A.M., the Administrator		shift and upon request, unless it is contraindicated by their medical condition. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be reeducated on providing fresh ice water each shift to all residents and upon request, unless it is contraindicated by their medical condition by January 13, 2025. DNS/Designee will round daily to ensure ice water is provided to residents unless contraindicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Hydration Pass” 3 times a week for 4 weeks, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	provided a policy titled, "Hydration Management," revised on 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of American Senior Communities to ensure that each resident is offered sufficient fluid intake to maintain proper hydration. 4. Hydration plans will be reviewed at a minimum of quarterly to determine if plan is still needed or requires revision. 9. Fresh water or other preferred beverages will be passed to all residents, unless medically contraindicated, on each shift....." 3.1-46(b)		**By what date the systemic changes will be completed:** January 14, 2025	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to store and serve food in a sanitary manner in the pantries, dining rooms, kitchen and kitchenettes. This had the potential to affect 57 of 57 residents who consumed food from the kitchen, pantries, dining rooms and kitchenettes. Findings include: 1. During the initial kitchen tour with the Culinary and Nutrition Manager (CNM) on 12/3/2024 at 9:45 A.M., 12/4/2024 at 8:30 A.M., 12/5/2024 at 11:20 A.M. and 12/6/2024 at 8:40 A.M. the following was observed: - the 6 burner gas range had a thick buildup of a black substance on all burner grates and below the grates. -there was a build up of grease on the stainless backsplash surrounding the gas range. -there was a build up of grease on the wall next to	F 0812	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** The main kitchen oven, range, surrounding backsplash/walls, handwashing sink and surrounding wall, vents, and floors in cooking area, dry storage and dish room have all been deep cleaned. The ice machine has been delimed, leak repaired, and surrounding walls cleaned. The dining room chair arms have been cleaned. The activity room and unit pantries oven, range, and refrigerator have all been deep cleaned. The activity room and unit pantries have disposed of all unlabeled and expired food, drink and condiments.	01/13/2025

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	the gas burners. -A ceiling vent had a black substance that looked like mold above the stainless steel prep table behind the ovens. -The handwashing sink was dirty with a red colored dried substance on the wall by the soap dispenser. -Two ovens had a build up of a black substance on the inside, and both ovens had a buildup of grease and food debris on the outside. -The floor was dirty in the cooking area, dishwashing room and the dry storage room. During an interview on 12/6/2024 at 8:45 A.M., the CDM indicated the cooking equipment, walls, floors, and ceiling vents were dirty and needed to be cleaned. He indicated the staff utilized a check list to clean the kitchen. 2. During an observation of meal service in the 2nd Floor Dining Room on 12/3/2024 at 11:58 A.M., the following was observed: - The black four burner range had food debris on all four burners. - The inside of the oven had a build up of grease and food debris. During an interview on 12/3/2024 at 12:00 P.M., Qualified Medication Aide 10 indicated the top of the range and inside of the oven were dirty and should be cleaned. She indicated it was the kitchen's job to clean the range and oven. During an interview with the Housekeeping Supervisor (HS) on 12/06/24 at 9:44 A.M.,she indicated it was the kitchen's responsibility to clean out the oven in the 2nd floor Dinning Room. 3. During an observation of meal service in the		**How will the facility identify other residents having the potential to be affected by this practice?** All residents have the potential to be affected by this practice; however, none were observed to be affected. The Culinary Manager has completed a sanitation review of the main kitchen, activity room and unit pantries to ensure proper labeling/dating of food/condiments, equipment clean and a sanitary environment. The Housekeeping Manager has completed a cleanliness review of the main dining room chairs and walls to ensure they are free of food debris. **What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?** Culinary staff will be reeducated on the cleaning schedule, proper labeling/dating, disposing of expired food or condiments, and maintaining a clean and sanitary environment. All staff will be reeducated on the proper labeling/dating, disposing of expired foods or condiments, cleanliness of the pantry refrigerator and a sanitary environment. The Culinary Manager, Housekeeping Manager or designee will make	

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	Main Dining Room on 12/3/2024 at 12:10 P.M., the following was observed: -A Puddle of water was under the ice machine. -The ice machine had a buildup of lime on the inside. -The wall behind the ice machine was dirty and had a brown substance splattered down the wall. -4 out of 14 chairs had a buildup food debris on the arms of the chairs. During an interview on 12/6/2024 at 8:45 A.M., the CDM indicated the ice machine needed to be delimed and it was the kitchen's responsibility to delime the inside of the ice machine. During an interview with the Housekeeping Supervisor (HS) on 12/06/2024 at 9:44 A.M., the HS indicated it was Housekeeping's responsibility to clean the dining room table, chairs and floors. During an interview with the Maintenance Director (MD) on 12/9/2024 at 9:05 A.M., the MD indicated the ice machine had been leaking. 4. During an observation of the Cottage's kitchenette on 12/5/2024 at 1:44 P.M., the following was observed: -A Clear container with 24 packs of single serve hot chocolate with no expiration dates. -A Clear container with packaged condiments that had no use by date. The container had 14 packets of tartar sauce, 12 packets of mild hot sauce, 2 packets of syrup and 2 packets of barbeque sauce. One packet of mild hot sauce was leaking an orange substance onto the other single serve condiment packages. During an interview on 12/5/2024 at 1:45 P.M.,		observations during daily rounding, corrections will be made immediately. Staff will be reeducated as necessary by applicable managers. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Culinary Service Manager or designee will conduct the QAPI audit tool “Kitchen Sanitation/Environmental Review” and the Housekeeping Manager or designee will conduct the QAPI audit tool “Dining Room Environmental Review”, 3 times a week for 4 weeks, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **Date of Compliance:** January 14, 2025	

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	LPN 6 indicated he was not able to identify when the hot chocolate or individual packets of condiments should be discarded. He indicated one of the hot sauce packets was leaking and all the packets should be thrown away. LPN 6 indicated it was the nursing staff's responsibility to throw away undated or expired food in the unit pantries and kitchenettes. 5. During an observation of the 100 Hall Unit Pantry on 12/5/2024 at 10:50 A.M., the following was observed: -A cake, dated 11/19/2024, with no resident identifying information. -A package of sliced turkey with no opened on or use by date. -5 single serve yogurt containers with an expiration date of 11/30/2024. -Two Zip Lock bags containing M & M candies with no resident identifying information and no opened on or use by date. -A half a stick of butter with no resident identifying information and no opened on or use by date. -There wasa large amount of a black substance that looked like mold on the bottom of the refrigerator. During an interview on 12/5/2024 at 10:53 A.M., LPN 7 indicated the cake and yogurt were expired and should be thrown away. She indicated the sliced turkey, M & M candies and the half a stick of butter should have contained resident identifying information, the date the food was opened and the date the food should be discarded. She indicated the mold on the bottom of the refrigerator should not be there and the mold should be cleaned. She believed the nursing staff was responsible for cleaning out the pantry			

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	refrigerators. 6. During an observation of the kitchenette in the Activities Room on 12/5/2024 at 1:45 P.M., the following was observed: -A one Gallon Ziploc bag of pizza sauce, dated 6/19/2024. -A one Gallon Ziploc bag of pizza sauce, dated 8/2/2024. -A Large block of butter with no opened on or use by dates. -A large Ziploc bag of shredded cheese, dated 10/20/2024. -The electric range had 4 burners and all 4 burners and their pans below the burners were dirty. -Inside of the oven had burnt on food debris. During an interview on 12/5/2024 at 1:48 P.M., Activates Assistant (AA) 8 indicated the left overs should be thrown away 7 days after opening, but if there was no opened on date, the food should be thrown away immediately. AA 8 indicated it was Housekeeping's responsibility to clean the range, oven and refrigerator. During an interview on 12/8/2024 at 10:00 A.M., the CDM indicated it was the kitchen's responsibility to clean all of the ranges, ovens and refrigerators in the building, including on the units and in the kitchenettes. On 12/5/2024 at 9:22 A.M., the Executive Director indicated the facility did not have a policy for maintaining the kitchen and the kitchen equipment, but the facility followed the Food and Drug Administration's (FDA) Food Code as a guide. During an interview on 12/5/2024 at 10:30 A.M.,			

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	the Corporate Nurse indicated the facility used the FDA Code as a guide for maintaining the kitchen, dining rooms, unit pantries and kitchenettes. On 12/6/2024 at 9:15 A.M., the Vice President of Operations supplied a cleaning schedule for the kitchen and identified the cleaning schedule as the one currently used by the facility. The cleaning schedule indicated, "...Ranges cleaned daily, Ovens cleaned on Saturday, ceiling vents cleaned monthly, sweep and mop floors daily..." 3.1-21(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure acceptable infection control standards were maintained during a surgical dressing change for 1 of 1 resident observed for a dressing change. (Resident 42) Finding includes: During an observation of a dressing change, on 12/3/2024 at 10:12 A.M., LPN 2 removed the soiled dressing from Resident 42's wound. LPN 2 then removed her gloves, pulled another pair of gloves out of her uniform pocket, donned them and proceeded to clean the resident's wound. Prior to starting the dressing change, LPN 2 had laid the supplies for the dressing change on the residents bed without placing a barrier between the resident's bed and the clean dressing supplies. A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 42 was discharged 12/4/24 and has not readmitted to facility. LPN#2 was immediately reeducated on dressing change clean technique. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving dressing changes have the potential to be affected by the same deficient practice. All nurses providing dressing changes will be observed for proper dressing change technique by January 13, 2025.	01/13/2025

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	osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. During an interview on 12/3/2024 at 10:28 A.M., LPN 2 indicated she should have washed her hands after she had removed the soiled dressing and she should have cleaned off the bedside table and placed a barrier down for the dressing supplies. On 12/3/2024 at 2:48 P.M., the DON provided a policy titled, "Dressing Change Clean Technique (Incision or Wound)", revised 10/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...8. Set up clean field with dressing change supplies and other necessary equipment. 10. Removed old dressing from the resident and put directly in trash receptacle. 11. Remove gloves and discard. 12. Perform hand hygiene....." 3.1-18(a)		**What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses will be reeducated on Dressing Change Clean Technique procedure. DNS/designee will observe nurse providing dressing changes per skills validation check off by January 13, 2025. DNS/Designee will conduct rounds during dressing changes to ensure proper infection control techniques are followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit Tool “Professional standards of practice for dressing changes” 3 x a week for 4 weeks, weekly x 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow-up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	12/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			By what date the systemic changes will be completed: January 14, 2025	