	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/09/2024	
	ROVIDER OR SUPPLIER END NURSING AND REHABILITATION	STREET A 4600 W SOUTH			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	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		The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. If acility is requesting a desk re in lieu of post survey revisit or after 1/14/2025.	ot s forth s, or The view	
F 0623 SS=D Bldg. 00	Notice Requirements Before		The facility requests a face to 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:	I	

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: N8UH11 Facility ID: 000246 If continuation sheet Page 1 of 22

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155355	B. W	ING		12/09/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ WASHINGTON AVE		
WESTR	END NURSING AN	D REHABILITATION			H BEND, IN 46619		
WEOTE	- IND NOROING AN	D REHABIEITATION		00011			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG				TAG	DEFICIENCY		DATE
	2:10 P.M. for Resident 4. Diagnoses included, but				The facility is unable to correct		
	were not limited to chronic obstructive pulmonary				deficient practice for Resident	: 4	
	disease, respiratory failure and heart failure.				due to transfer occurring in		
	A Cincificant Change Minimum Data Cat (MDC)				October 2024 and Resident 1		
	A Significant Change Minimum Data Set (MDS)				transfer occurring in Septemb	er	
	· ·	0/23/2024, indicated Resident			2024.		
	4's cognition was in	ntact.			Nurses will be reeducated on		
					Hospital/Discharge Transfer F	Policy	
		15 P.M., Nursing Progress notes			by January 13, 2025.		
		4 was found unresponsive.			How other residents having		
		t and notification to the			potential to be affected by the		
		t 4 was sent to the emergency			same deficient practice will I		
		was notified by phone of the			identified and what corrective	re	
		ord lacked documentation that			action(s) will be taken:		
		Transfer/Discharge form was			All residents who have been		
	provided to the resi	dent or her husband.			transferred to acute care setti	-	
	Daning on internal				the past have the potential to		
	_	v on 12/05/24 at 2:16 P.M., the was no documentation of the			affected by the same deficient		
	transfer paperwork,				practice, due to the occurrence		
		form for Resident 4.2. During			happening in the past deficien		
	_	3/2024 at 10:31 A.M., Resident			practice for those residents ar not able to be corrected. Any		
		d been to the hospital in the			resident transferred within the		
	last four months.	d been to the hospital in the			15 days will have the Notice of		
	last four months.				Transfer/Discharge form will b		
	A Nursing Progress	s note, dated 9/19/2024 at 6:30			provided to the resident and	.~	
		sident 16 was sent to the			mailed to the resident		
	· ·	ment (ER) due to lower back			representative. To correct the	,	
	pain and vomiting.	(===) === == ====			action for future		
					transfers/discharges nurses w	/ill be	
	A Nursing Progress	s note, dated 9/19/2024 at 7:49			reeducated on the	-	
		Director of Nursing, Resident			Hospital/Discharge Transfer		
		Primary Care Physician had			Policy.		
	_	resident's transfer to the ER.			What measures will be put in	,	
					place or what systemic		
	A Nursing Progress note, dated 9/20/2024 at 6:25				changes will be made to		
	A.M., indicated Resident 16 was admitted to the				ensure that the deficient		
	hospital.				practice does not recur:		
	_				Nurses will be reeducated on		
	A Nursing Progress	s note, dated 10/4/2024 at 7:48			Hospital/Discharge Transfer F	Policy	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED
		155355	B. W	ING		12/09/	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			/ WASHINGTON AVE		
WEST D	END NI IDRING AN	ID REHABILITATION			BEND, IN 46619		
WESTB	DEND NORSING AN	ID REHABILITATION		300111	1 BEND, IN 40019		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		sident 16's family was			by January 13, 2025.		
	concerned about the resident's health and				DNS/designee will review nurs	sing	
requested the resident be sent to the hospital for				documentation daily Monday			
evaluation.				through Friday for			
					hospital/discharge transfers.	IDT	
		s note, dated 10/4/2024 at 8:00			will complete the IDT transfer		
	· ·	er assessing the resident, the			review tool with each		
		ency Services and the resident			transfer/discharge to ensure r	otice	
	had been transporte	ed to the hospital.			of transfer/discharge form is		
					provided to the resident and		
		the documentation that a			resident representative.		
	_	assessment and forms had			How the corrective action(s)		
	•	conjunction with Resident 16's			will be monitored to ensure	ihe	
	1	oital on 9/20/2024 and			deficient practice will not		
	10/4/2024.				recur, i.e., what quality		
	D	12/5/2024 + 2.17 D.M (1			assurance program will be p	ut	
	-	w on 12/5/2024 at 2:16 P.M., the			into place:		
) indicated the record lacked			Ongoing compliance with this		
		aperwork, which included the nd bed hold policy paperwork.			corrective action will be monit	orea	
	notice of transfer a	nd bed noid poncy paperwork.			through the facility Quality Assurance and Performance		
	On 12/5/2024 a no	licy was requested regarding			Improvement Program (QAPI)	١	
		transfer/discharge assessment			The Ed/designee will be	1-	
		ovided prior to the survey exit.			responsible for completing the	2	
	und one was not pr	ovided prior to the survey exit.			QAPI Audit Tool	,	
	3.1-12(a)(6)(A)				"Transfer/Discharges/Bed Hol	ď"	
	211 12(w)(v)(11)				weekly for 4 weeks, monthly f		
					months and quarterly thereaft		
					at least 2 quarters. If the	01 101	
					threshold of 90% is not met, a	ın	
					action plan will be developed.		
					Findings will be submitted to t		
					QAPI Committee for review a		
					follow-up.		
					By what date the systemic		
					changes will be completed:		
					January 14, 2025		
					-		
F 0625	483.15(d)(1)(2)						
SS=D	Notice of Red Ho	ld Policy Refore/Upon Trosfr					İ

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155355	B. W	NG		12/09/	/2024
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MEGT		D DELLA DIL ITA TIONI			/ WASHINGTON AVE		
WEST BE	END NURSING AN	D REHABILITATION		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
Bldg. 00							
_	Based on interview	and record review, the facility	F 0	525	The facility requests a face to	face	01/13/2025
failed to provide a copy of the Bed Hold Policy to				IDR for F625. The facility			
residents when admitted to the hospital for 2 of 2				disagrees with the scope and			
		for hospitalization. (Residents			severity cited for F625.		
	4 and 16)	•					
	·				What corrective action(s) wil	.I	
	Findings include:				be accomplished for those		
					residents found to have been	า	
	1. A record review	was completed on 10/3/2024 at			affected by the deficient		
	2:10 P.M. for Resid	lent 4. Diagnoses included, but			practice:		
	were not limited to	chronic obstructive pulmonary			The facility is unable to correc	t	
		failure and heart failure.			deficient practice for Resident		
					due to transfer occurring in		
	A Significant Chan	ge Minimum Data Set (MDS)			October 2024 and Resident 16	6	
		0/23/2024, indicated Resident			transfer occurring in Septembe	er	
	4's cognition was in				2024.		
					Nurses will be reeducated on	Bed	
	On 10/5/2024 at 6:1	5 P.M., Nursing Progress Notes			Hold Policy by January 13, 20	25	
	indicated Resident	4 was found unresponsive.					
	After an assessmen	t and notification to the			How other residents having t	the	
	physician, Resident	4 was sent to the emergency			potential to be affected by th	e	
	room. Her husband	was notified by phone of the			same deficient practice will be	Эе	
	transfer but the reco	ord lacked documentation that			identified and what correctiv	е	
	the Bed Hold Police	y was provided to the resident			action(s) will be taken:		
	or her husband.				All residents who have been		
					transferred to acute care hosp	ital	
	During an interview	on 12/05/24 at 2:16 P.M., the			in the past have the potential t	io be	
	ED indicated there	was no documentation of the			affected by the same deficient	•	
	transfer paperwork,	including the			practice, due to the occurrence	е	
	_	form for Resident 4.2. During			happening in the past deficien	t	
	an interview on 11/	3/2024 at 10:31 A.M., Resident			practice for those residents are	е	
		d been to the hospital in the			not able to be corrected. Any	y	
	last four months and	d did not recall receiving a bed			resident transferred within the	last	
	hold policy.				15 days will have the bed hold	l l	
					policy provided to the resident	and	
		note, dated 9/19/2024 at 6:30			mailed to the resident	ļ	
		ident 16 was sent to the			representative. To correct the	ļ	
	Emergency Departr	ment (ER) due to lower back			action for future temporary	ļ	
	pain and vomiting.				transfers/discharges nurses w	ill be	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155355	B. W	ING		12/09/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			/ WASHINGTON AVE		
WESTRI	END NI IBSING AN	D REHABILITATION			BEND, IN 46619		
WEST BI	END NORSING AN	D REHABILITATION		30011	1 BEND, IN 400 19		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
				reeducated on the Bed Hold			
A Nursing Progress note, dated 9/19/2024 at 7:49				Policy.			
	P.M., indicated the Director of Nursing, Resident				What measures will be put in	ו	
	16's family and Primary Care Physician were				place or what systemic		
		t was being transferred to the			changes will be made to		
	ER.				ensure that the deficient		
					practice does not recur:		
		s note, dated 9/20/2024 at 6:25			Nurses will be reeducated on		
	· · · · · · · · · · · · · · · · · · ·	sident 16 was admitted to the			Hold Policy by January 13, 20		
	hospital.				DNS/designee will review nurs	sing	
					documentation daily Monday		
	A Nursing Progress note, dated 10/4/2024 at 7:48				through Friday for transfers		
	l '	sident 16's family was			requiring Bed Hold and ensure		
		e resident's health and			bed hold policy is provided to	the	
		ent be sent to the hospital for			resident and resident		
	evaluation.				representative.		
					How the corrective action(s)		
		s note, dated 10/4/2024 at 8:00			will be monitored to ensure	the	
		er assessing the resident, the			deficient practice will not		
	_	ency Services and the resident			recur, i.e., what quality		
	was transported to t	the hospital.			assurance program will be p	ut	
					into place:		
		the documentation that a bed			Ongoing compliance with this		
		ovided to the resident in			corrective action will be monit	ored	
		esident 16's transfer to the			through the facility Quality		
	hospital on 9/20/20	24 and 10/4/2024.			Assurance and Performance		
	Duning on intermi	v on 12/5/2024 at 2:16 P.M., the			Improvement Program (QAPI)).	
	_				The Ed/designee will be		
) indicated the record lacked aperwork, which included the			responsible for completing the	;	
		aperwork, which included the add bed hold policy paperwork.			QAPI Audit Tool	d"	
	nonce of transfer at	на оса пота ропсу рарегиотк.			"Transfer/Discharges/Bed Hol weekly for 4 weeks, monthly f		
	On 12/5/2024 of 2:3	30 P.M., the ED provided the			1		
		Hold Policy", dated 11/2017			months and quarterly thereaft at least 2 quarters. If the	CI IOI	
					threshold of 90% is not met, a	, l	
and indicated it was the policy currently being				action plan will be developed.	""		
used by the facility. The policy indicated "Purpose of Policy: Provide guidance to facility				Findings will be submitted to t	he		
	staff for holding a bed for a resident transfer. 2.				QAPI Committee for review a		
		be provided the bed hold policy				ıu	
		ospital transfer or therapeutic			follow-up.		
	at the time of the no	ospitai transiei oi merapeune	1		By what date the systemic		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155355	B. W.	ING		12/09	/2024
NAME OF F	PROVIDER OR SUPPLIER	<u>. </u>	•		ADDRESS, CITY, STATE, ZIP COD		
					/ WASHINGTON AVE		
WEST BI	END NURSING AN	D REHABILITATION		SOUTH	H BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	notification to the re	y staff will document the			changes will be completed:		
		e bed hold policy on the			January 14, 2025		
	1 -	nt Transfer Form"					
	Lineigency Resider	it fransici i offil					
	3.1-12(25)(A)(B)						
F 0657	483.21(b)(2)(i)-(iii)						
SS=D	Care Plan Timing						
Bldg. 00							
		and record review, the facility	F 00	657	What corrective action(s) wi	II	01/13/2025
		Plan meetings with residents			be accomplished for those		
	_	ntatives timely for 2 of 3			residents found to have bee	n	
		re Plan meetings were			affected by the deficient		
	reviewed. (Residen	15 4 / 62 30)			practice:	forod	
	Findings include:				Resident #38 and #47 was of a care plan meeting with IDT.		
	1 manigo morado.				plan meeting occurred with	Juic	
	1. During an intervi	ew on 12/03/2024 at 2:13 P.M.,			resident, and/or responsible p	artv.	
		ed he had not been to a Care			How other residents having	-	
	Plan meeting with t				potential to be affected by the		
	-				same deficient practice will		
		d review was completed on			identified and what corrective	/e	
		.M. Resident 46 had a Minimum			action(s) will be taken:		
		sessment completed on the			All other residents have the		
	following dates:				potential to be affected. All cu		
	11/10/2024 2	1 MDC			residents were audited to ens		
		rly MDS assessment			care plan meeting was held w	/ithin	
	1	ant Change MDS assessment			the last 90 days	_	
	-5/31/2024 Quarter	-			What measures will be put in	n	
	-5/14/2024 Quarter -3/19/2024 Annual				place or what systemic		
	-3/19/2024 Annual -1/2/2024 Quarterly				changes will be made to ensure that the deficient		
	-1/2/2024 Quarterly	MIDO OSSESSIIICIII			practice does not recur:		
	There was no docur	mentation a Care Plan meeting			Social Services Director and		
		nd been conducted following			Memory Care Support Specia	ılist	
		essments, except after the			will be reeducated regarding		
	2/18/2024 Annual M	-			expectation of quarterly care		
					meetings. All residents in thei		
	During an interview	on 12/5/2024 at 2:34 P.M., the			MDS assessment period will		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155355	B. W	ING		12/09/	2024
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ WASHINGTON AVE		
WEST D	ENID NILIDOINIO ANI	D DEHABILITATION					
NE21BI	END NOKSING AN	D REHABILITATION		30016	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Social Services Director indicated she had met				discussed daily to ensure a		
	with Resident 47 regularly, but had not had a Care				quarterly care plan meeting ha		
Plan meeting with him following his MDS				been scheduled. Social Service	ces		
	assessments.				and Memory Care Support		
					Specialist will implement a		
	_	v on 12/6/2024 at 8:45 A.M., the			tracking log for all residents w		
		indicated Resident 47 had not			the date of quarterly care plan		
		meetings regularly after his			meeting held, logs to be turne	d	
	MDS assessments.				into ED weekly to ensure	, ,	
		10/4/2024 - 12 15 135			residents are invited to a quar	terly	
	2. During an interview on 12/4/2024 at 10:45 A.M.,				care plan meeting.		
Resident 38 indicated she had not met with staff				How the corrective action(s)			
	about her care plan	in a long time.			will be monitored to ensure t	the	
		1 4 1 10/5/2024 4			deficient practice will not		
		as completed on 10/5/2024 at			recur, i.e., what quality		
		lent 38. Diagnoses included, but			assurance program will be p	ut	
		hypertension, general anxiety			into place:		
	disorder and depres	ssion.			Ongoing compliance with this		
	An Annual Minimu	ım Data Set (MDS) assessment,			corrective action will be monite	orea	
		dicated Resident 38's cognition			through the facility Quality Assurance and Performance		
	was intact.	dicated Resident 38's cognition					
	was ilitact.				Improvement Program (QAPI) The Ed/designee will be).	
	Resident 38's record	d lacked the documentation a			responsible for completing the	,	
		had been conducted on a			QAPI Audit Tool "IDT Care Pla		
	_	Resident 38 and/or her			Review" weekly for 4 weeks,	all	
		6/6/2024 through 12/5/2024.			monthly for 6 months and		
	1 spresemunte from	. 0. 0. 202 i dirough 12/0/202 i.			quarterly thereafter for at leas	t 2	
	During an interview	v on 12/05/24 at 2:45 P.M., the			quarters. If the threshold of 9		
	_	ctor (SSD) indicated that she			is not met, an action plan will		
		rmal care plan meetings with			developed. Findings will be		
	1	ould have had them after			submitted to the QAPI Commi	ittee	
		nts were completed on			for review and follow-up.		
	8/14/2024 and on 1						
					By what date the systemic		
	On 12/5/2024 at 3:0	00 P.M. a current policy, dated			changes will be completed:		
8/2023, and titled, "IDT Comprehensive Care Plan				January 14, 2025			
	Policy" was provided by the SSD. The policy]		
		g the meeting all IDT members					
		resident and/or representative					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CONSTRUCTION (X. A. BUILDING <u>00</u> B. WING			COMPL	X3) DATE SURVEY COMPLETED 12/09/2024	
	PROVIDER OR SUPPLIEI	REHABILITATION	•	4600 V	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION
F 0658 SS=D	at the bedside, or rethe time mutually a resident and/or representation of the time mutually a resident and/or representation of the time mutually a resident and/or representation of the time mutually at the bedside, or rether the time mutually at the time mutu	esident's desired location, at greed upon by SS, IDT, resentative"		IAG	DETAILECT		DATE
Bldg. 00	Standards Based on observati review, the facility met professional sta dressing changes for wounds. (Resident Finding includes: During an observat at 9:41 A.M., Resid supposed to get her it had not been com asked the evening se completed her dres covering the reside amputation revision When Resident 42 was a large amount drainage, an openir erythema around th During an observat at 10:12 A.M., LPN left leg was ordered current dressing was LPN 2 indicated Re building with a frie and had requested to	on, interview and record failed to 1 of 1 staff (LPN 2) andards regarding signing off or 1 of 3 residents reviewed for	F 06	558	It is the practice of this facility ensure that residents receive treatment and care in accorda 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 readmitte facility. LPN#2 was immediately educiby Clinical Educator. How other residents having to 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 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	ance II In ated to ated the ne ne oe ated	01/13/2025

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

Event ID:

N8UH11 Facility ID: 000246

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155355	B. WING		12/09/2024
		R D REHABILITATION STATEMENT OF DEFICIENCIE	4600 W	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE I BEND, IN 46619	(V5)
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION as completed for Resident 42 on	TAG	ensure that the deficient	DATE
		P.M. Diagnoses included, but		practice does not recur:	
		: chronic hematogenous		Nurses will be reeducated on	
		femur-distal, infection following		professional standards of practical	rtice
	-	c obstructive pulmonary		for dressing changes.	hiloc
	_	astolic heart failure, acquired		DNS/Designee will round daily	,
		above the knee and acquired		Monday through Friday to ens	
	_	g above the knee, peripheral		dressings are changed per Mi	
		nd atherosclerosis of native		order and per protocol.	
		ies with intermittent		How the corrective action(s)	
	claudication, bilate			will be monitored to ensure	
	,	5		deficient practice will not	
	A Physician Order,	dated 11/27/2024 indicated the		recur, i.e., what quality	
		rgical above the knee wound to		assurance program will be p	ut
	_	d wash, dry, apply skin prep		into place:	
		ound bed and cover with an		Ongoing compliance with this	
	abdominal dressing	g and wrap with kerlix dressing.		corrective action will be monit	ored
				through the facility Quality	
	A Current Care Pla	n, dated 10/30/2024, indicated		Assurance and Performance	
	impaired skin integ	rity related to a surgical wound,		Improvement Program (QAPI)).
	with the following	intervention of treatment as		The ED/designee will be	
	ordered.			responsible for completing the	;
				QAPI Audit Tool "Professional	
	A Treatment Admi	nistration Record, for		standards of practice for dress	sing
	December, dated 1	2/1/2024 - 12/4/2024, indicated		changes" 3 x a week for 4 week	eks,
	the dressing was do	ocumented as changed on		weekly x 4 weeks, monthly for	· 6
	12/1/2024 and 12/2	2/2024.		months and	
	LPN 2 indicated sh 42's dressing and t	v on 12/4/2024 at 3:18 P.M., e had not changed Resident he dressing changes should		By what date the systemic changes will be completed: January 14, 2025	
	not have been signed TAR for 12/1/2024	ed off as completed on the and 12/2/2024.			
	On 12/4/2024 at 3:4 but one was not pro	40 P.M., a policy was requested ovided.			
	3.1-50(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: N8UH11 Facility ID: 000246 If continuation sheet Page 9 of 22

DESTIFICATION NUMBER 155355 NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION IN THE PREFER (EACH DEPCEISEY MUST BE PRECEDED BY PILL TAG INCIDENCE SOUTH BEND, IN 46619) SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY PILL TAG INCIDENCE SOUTH BEND, IN 46619 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY PILL TAG INCIDENCE SOUTH BEND, IN 46619 Based on observation, interview, and record review, facility failed to ensure a resident received a treatment per the physician order for 1 of 3 residents reviewed for skin condition. (Resident 42) Finding includes: During an observation and interview, on 12/3/2024 at 941 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 requised the evening shift staff to complete fit, 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 hose and a large amount of reddish-brown thick drainings was noted when the resident pulled back the edge of the dressing, the center of the wound had in 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 2001 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyellis, left femur-disalel, infection following a procedure, chronic obstructive pulmonary disease, chronic disabotic heart failure, acquired absence of left leg obove the knee and acquired ubsence of right leg above the knee, peripheral vascular disease, and atheroselerosis of native arrives of extramities with intermittent chadication, bilateral legs. A Current Care Plan, dated 10/30/2024, indicated impried skin integrity related to a surgical wound,	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (LACII DEPICIENCY MIST II BERICEDED IN PRIETIX (LACII DEPICIENCY MIST II BERICEDED IN PRIETIX (LACII DEPICIENCY MIST II BERICEDED IN PRIETIX TAG REQUILATIONY OR ISE DENTIFYING INFORMATION TAG SSS—D Bidg, 00 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 39-41 A.M., Resident 42 indiated she was supposed to have gents he for design of the decising of the decision of	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155355	B. WING		12/09/2024
WEST B		D REHABILITATION	4600 W SOUTH	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE H BEND, IN 46619	(V5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG			TAG		
TAG	with the following ordered. A Physician Order, following: -left surcleanse with wound then xeroform to wabdominal dressing. During an observat at 10:12 A.M., LPN left leg was ordered was dated 11/30., for Resident 42 went of on 12/1/2024 and 1 dressing changes be returned from her of the evening shift dressing change confrom her leave of al 12/2/2024. The dresthough the TAR (Tinaccurately signed and 12/2/2024. A Nursing Progress P.M., indicated Resident and 12/2/2024. A Nursing Progress P.M., indicated Resident and 12/5/2024 at 8:30 they did not have a orders was just the	v on 12/4/2024 at 3:18 P.M., e had not passed on in report that Resident 42 needed her impleted when she returned besence on 12/1/2024 and ssing was not changed, even freatment Record) had been as completed on 12/1/2024 s note, dated 12/1/2024 at 1:15 sident 42 had requested her in place as she was going out	TAG	How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place: Ongoing compliance with this corrective action will be monitor 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 dress changes" 3 x a week for 4 weekly x 4 weeks, monthly for months and quarterly thereafted at least 2 quarters. If the threshold of 90% is not met, a action plan will be developed. Findings will be submitted to to QAPI Committee for review are follow-up. By what date the systemic changes will be completed: January 14, 2025	the ut ored i. e. l. sing eks, e. 6 er for n he
	3.1-37(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED
		155355	B. WI	NG		12/09/2024
NAME OF I	PROVIDER OR SUPPLIE	R		STREET .	ADDRESS, CITY, STATE, ZIP COD	
					/ WASHINGTON AVE	
WEST B	END NURSING AN	ID REHABILITATION		SOUTH	H BEND, IN 46619	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE
F 0757	483.45(d)(1)-(6)					
SS=D		Free from Unnecessary				
Bldg. 00	Drugs					
		and record review, the facility	F 07	57	What corrective action(s) wil	II 01/13/2025
		idents were free from antibiotic			be accomplished for those	
		or an excessive duration for 1 of			residents found to have been	n
		ed for unnecessary medications.			affected by the deficient	
	(Resident 41)				practice:	
					Resident 41 antibiotic was	
	Finding includes:				discontinued per order.	
					How other residents having	
		as completed on 12/5/2024 at			potential to be affected by the	
		sident 41. Diagnoses included			same deficient practice will be	I
		d to: acute osteomyelitis of left			identified and what correctiv	'e
		stage 2 pressure ulcer on left			action(s) will be taken:	
	heel.				All residents receiving antibiot	I
					have the potential to be affect	I
		nimum Data Set (MDS)			by the same deficient practice	I
		10/7/2024, indicated Resident			All residents receiving antibiot	ics
	_	intact and he received			will be audited to determine	
	antibiotic medication	on.			appropriateness, MD/NP will b	ре
					notified as necessary.	
		Orders included, but were not			What measures will be put in	1
		xin (an antibiotic) ordered on			place or what systemic	
		illigrams by mouth every 8 hours			changes will be made to	
	1	nfection. The antibotic was to			ensure that the deficient	
	_	ed and discontinued on			practice does not recur:	
	12/4/2024.				Nurses/MD/NP will be reeduce	
					on Antibiotic Stewardship Prog	-
		11/30/2024, indicated a urine			by January 13, 2025. IP nurse	I
	_	no bacterial growth as the final			review Facility Activity Report	-
		did not notify the Nurse			and follow up for appropriaten	
	· ·	0/2024 of the need to			of antibiotic usage, any conce	
	discontinue the ant	ibiotic treatment.			identified the MD will be notified	
					How the corrective action(s)	I
		ed 12/5/2024, indicated the			will be monitored to ensure t	the
		ontinued by the Nurse			deficient practice will not	
		no growth in the resident's			recur, i.e., what quality	
	urine, 5 days after	the lab result was received.			assurance program will be p	ut
I					into place:	ĺ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 12/09/2024			
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION		4600 V	ADDRESS, CITY, STATE, ZIP COD W WASHINGTON AVE H BEND, IN 46619		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	During an interview Infection Prevention stop antibiotics due 11/30/2024. On 12/3/2024 at 1:0 January 2023 and ti Program" was prove The policy indicated establish key eleme	on 12/6/2024 at 1:14 P.M., the hist indicated it was normal to to the lab results from 100 P.M. a current policy, dated tled, "Antibiotic Stewardship ided by the Executive Director. d,"The facility shall nts for antibiotic prescribing hitor and manage antibiotic	TAG	Ongoing compliance with this corrective action will be monitour 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 weekly x 4 weeks, monthly for months and quarterly thereafted at least 2 quarters. If the threshold of 90% is not met, a 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	eks, 6 er for n
F 0807 SS=D Bldg. 00	Based on observation review, the facility received fresh ice was a residents reviewed. Finding includes: During an observation at 12:05 P.M., Residents fresh ice water He indicated he deshis room. He indicated delivered was on 11	cet Needs/Prefs/Hydration on, interview and record failed to ensure a resident vater per his preference for 1 of d for hydration. (Resident 21) don and interview, on 12/4/2024 dent 21 indicated he had did not r delivered daily to his room. ired to have fresh ice water in ated the last date he had water /13 and 11/29.	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 provide with fresh ice water. How other residents having 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 be affected. All residents will be provided with fresh ice water of	ed the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B				COMPLETED	
		155355	B. W	ING		12/09/	2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			WASHINGTON AVE			
WEST BE	END NURSING AN	D REHABILITATION			I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
1110		ent 21 indicated staff did not			shift and upon request, unless	it is	Bill	
	· · · · · · · · · · · · · · · · · · ·	and to go to the nurse's station			contraindicated by their medic			
	_	order to have a drink of water.			condition.	, cai		
		01 H01 10 H01 0 H H11H1 01 WH11H			What measures will be put in	,		
	During an observat	ion on 12/5/2025 at 9:42 A.M.,			place or what systemic	•		
		f water in Resident 21's room.			changes will be made to			
	1				ensure that the deficient			
	A record review wa	as completed on 12/4/2024 at			practice does not recur:			
		dent 21. Diagnoses included,			All nursing staff will be reeduc	ated		
		d to: hemiplegia and			on providing fresh ice water ea			
		ing nontraumatic intracerebral			shift to all residents and upon			
	_	eting left dominant side, type 2			request, unless it is			
	_	ith hyperglycemia, hemiplegia			contraindicated by their medic	al I		
		llowing nontraumatic			condition by January 13, 2025			
		orrhage affecting right		DNS/Designee will round daily to				
		and anxiety disorder.			ensure ice water is provided to			
		•			residents unless contraindicat			
	A Quarterly Minim	um Data Set (MDS)			How the corrective action(s)			
	assessment, dated 9	0/26/2024, indicated resident			will be monitored to ensure t			
	required set up assi	stance for eating and had			deficient practice will not			
	upper and lower bo	dy range of motion impairment			recur, i.e., what quality			
	to one side of his be	ody.			assurance program will be p	ut		
					into place:			
	A Quarterly Hydrat	tion Review assessment, dated			Ongoing compliance with this			
	11/11/2024, indicat	ted Resident 21 required			corrective action will be monite	ored		
	assistance with foo	d and fluids.			through the facility Quality			
					Assurance and Performance			
		n, dated 6/26/2024, indicated			Improvement Program (QAPI)	. The		
	_	ed assistance or monitoring of			DNS/designee will be respons			
	1	and elimination. The plan did			for completing the QAPI Audit			
		dent's desire to have fresh ice			"Hydration Pass" 3 times a we			
	water in his room.				for 4 weeks, weekly for 4 wee	ks,		
					monthly for 6 months and			
		v on 12/5/2024 at 9:43 A.M.,			quarterly thereafter for at leas			
		she only provided water to			quarters. If the threshold of 90			
		ed it and she did not just leave			not met, an action plan will be			
		rooms for them. She indicated			developed. Findings will be			
	that Resident 21 co	uld do things for himself.			submitted to the QAPI Commi	ttee		
					for review and follow up.			
	L On 12/9/2024 at 10	:00 A M the Administrator	1		İ			

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPL		
		155355	B. WING 12/09/2024				
NAME OF D	ROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP COD		
					WASHINGTON AVE		
WEST BEND NURSING AND REHABILITATION			SOUTH	I BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	provided a policy ti	-			By what date the systemic		
	-	sed on 11/2017, and indicated			changes will be completed:		
		one currently used by the indicated "It is the policy of			January 14, 2025		
		ommunities to ensure that each					
		ufficient fluid intake to					
		lration. 4. Hydration plans					
		a minimum of quarterly to					
		still needed or requires					
	_	water or other preferred					
		assed to all residents, unless					
	medically contraind	icated, on each shift"					
	21.464)						
	3.1-46(b)						
F 0812	483.60(i)(1)(2)						
SS=F	Food						
Bldg. 00	Procurement,Store	e/Prepare/Serve-Sanitary					
		on, interview and record	F 08	312	How will corrective action be	;	01/13/2025
	-	failed to store and serve food			accomplished for those		
		r in the pantries, dining rooms,			residents found to have beer	1	
		ettes. This had the potential			affected by the deficient		
		sidents who consumed food			practice?		
	-	intries, dining rooms and			The main kitchen oven, range		
	kitchenettes.				surrounding backsplash/walls, handwashing sink and surrour		
	Findings include:				wall, vents, and floors in cooki	-	
					area, dry storage and dish roo	-	
	1. During the initial	kitchen tour with the Culinary			have all been deep cleaned. T		
		ger (CNM) on 12/3/2024 at			ice machine has been delimed		
		24 at 8:30 A.M., 12/5/2024 at			leak repaired, and surrounding	-	
	11:20 A.M. and 12/	6/2024 at 8:40 A.M. the			walls cleaned. The dining roor		
	following was obser	rved:			chair arms have been cleaned	l.	
					The activity room and unit pan		
	_	inge had a thick buildup of a			oven, range, and refrigerator h	nave	
		all burner grates and below			all been deep cleaned. The		
	the grates.				activity room and unit pantries		
		p of grease on the stainless			have disposed of all unlabeled	l and	
	backsplash surround				expired food, drink and		
	-there was a build u	p of grease on the wall next to			condiments.	ļ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (00) COMPLE B. WING 12/09/2			ETED	
NAME OF	F PROVIDER OR SUPPLIE	R	<u> </u>	1	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE	<u> </u>	
WEST	BEND NURSING AN	ID REHABILITATION		SOUTH	H BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the gas burners.						
	-	l a black substance that looked			How will the facility identify		
		e stainless steel prep table			other residents having the		
	behind the ovens.				potential to be affected by the	nis	
	_	sink was dirty with a red			practice?		
		ance on the wall by the soap			All residents have the potent	al to	
	dispenser.				be affected by this practice;		
		build up of a black substance			however, none were observed		
	· ·	ooth ovens had a buildup of			be affected. The Culinary Mai	•	
	grease and food de				has completed a sanitation re		
		y in the cooking area,			of the main kitchen, activity ro		
	dishwashing room	and the dry storage room.			and unit pantries to ensure pr	-	
	1				labeling/dating of food/condin		
	"	w on 12/6/2024 at 8:45 A.M., the			equipment clean and a sanita	-	
		e cooking equipment, walls,		environment. The Housekeeping			
	_	vents were dirty and needed to		Manager has completed a			
		icated the staff utilized a check		cleanliness review of the main			
	list to clean the kite	chen.			dining room chairs and walls	í O	
					ensure they are free of food		
	_	vation of meal service in the			debris.		
	_	Room on 12/3/2024 at 11:58					
	A.M., the following	g was observed:			What measures will be put in		
	T1 11 1 C 1	1 10 111 '			place or systematic changes	>	
		irner range had food debris on			made to ensure that the		
	all four burners.				deficient practice will not		
		oven had a build up of grease			reoccur?	امما	
	and food debris.				Culinary staff will be reeducat		
	During on interview	w on 12/3/2024 at 12:00 P.M.,			on the cleaning schedule, pro	per	
	-	on Aide 10 indicated the top of			labeling/dating, disposing of expired food or condiments, a	and	
	-	e of the oven were dirty and			T		
	_	She indicated it was the			maintaining a clean and sanit environment. All staff will be	aı y	
		an the range and oven.			reeducated on the proper		
	Kitchen's job to cle	an and range and oven.			labeling/dating, disposing of	ļ	
	During an interview	w with the Housekeeping			expired foods or condiments,	ļ	
	_	12/06/24 at 9:44 A.M.,she			cleanliness of the pantry		
		e kitchen's responsibility to			refrigerator and a sanitary	ļ	
		in the 2nd floor Dinning Room.			environment. The Culinary		
	Cican out the oven	in the 2nd floor Dillining Room.			Manager, Housekeeping Man	lager	
	3 During an obser	vation of meal service in the			or designee will make	ayei	
	J. During an obser	, action of infour bot vice in the	I		or acaigned will make		I

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPI			ETED	
		155355	B. W	B. WING 12/09/2024				
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R			/ WASHINGTON AVE			
WEST BI	END NI IBSING AN	ID REHABILITATION			BEND, IN 46619			
WEST DI	END NORSING AN	ID REHABILITATION		300111	1 BEND, IN 40019			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Main Dining Room	n on 12/3/2024 at 12:10 P.M., the			observations during daily rour	ıding,		
	following was obse	erved:			corrections will be made			
					immediately. Staff will be			
	-A Puddle of water	was under the ice machine.			reeducated as necessary by			
	-The ice machine h	ad a buildup of lime on the			applicable managers.			
	inside.							
		ne ice machine was dirty and			How will the facility monitor	its		
	had a brown substa	nce splattered down the wall.			corrective actions to ensure			
		had a buildup food debris on			that the deficient practice wi	II		
	the arms of the cha	irs.			not recur?			
					Ongoing compliance with this			
	_	w on 12/6/2024 at 8:45 A.M., the			corrective action will be monit	ored		
		ice machine needed to be			through the facility Quality			
		the kitchen's responsibility to			Assurance and Performance			
	delime the inside o	f the ice machine.			Improvement Program (QAPI)). The		
					Culinary Service Manager or			
	_	w with the Housekeeping			designee will conduct the QAI	기		
		12/06/2024 at 9:44 A.M., the			audit tool "Kitchen			
		s Housekeeping's responsibility			Sanitation/Environmental Rev			
	to clean the dining	room table, chairs and floors.			and the Housekeeping Manag	-		
					designee will conduct the QAI	기		
		w with the Maintenance			audit tool "Dining Room			
		12/9/2024 at 9:05 A.M., the MD			Environmental Review", 3 time			
	indicated the ice m	achine had been leaking.			week for 4 weeks, weekly for			
					weeks, monthly for 6 months			
	_	vation of the Cottage's			quarterly thereafter for at leas			
		/2024 at 1:44 P.M., the			quarters. If the threshold of 90			
	following was obse	erved:			not met, an action plan will be	:		
	A C1 ('				developed. Findings will be	:44		
		with 24 packs of single serve			submitted to the QAPI Commi	ttee		
		no expiration dates.			for review and follow up.			
		with packaged condiments that			Data of Compliance Janven	. 1.1		
		The container had 14 packets			Date of Compliance: January	14,		
		packets of mild hot sauce, 2			2025			
		nd 2 packets of barbeque						
	_	of mild hot sauce was leaking						
	_	e onto the other single serve						
	condiment package	S.						
	During an interview	w on 12/5/2024 at 1:45 P.M.,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		UILDING	instruction 00	(X3) DATE COMPL 12/09/	ETED	
	PROVIDER OR SUPPLIEI	R REHABILITATION	4600 W	NDDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY 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) COMPLETION DATE
	the hot chocolate of condiments should one of the hot sauce the packets should indicated it was the to throw away undapantries and kitcher 5. During an observed: 5. During an observed: -A cake, dated 11/1 identifying information -A package of slice use by date. 5. Single serve yog expiration date of 1 -Two Zip Lock bag with no resident ideopened on or use by -A half a stick of beindentifying information by date. -There was a large at that looked like more frigerator. During an interview LPN 7 indicated the and should be throw sliced turkey, M & of butter should havidentifying information opened and the date discarded. She individed the refrigerators of the refrigerators of the refrigerator of the refrigerators.	yation of the 100 Hall Unit 4 at 10:50 A.M., the following 9/2024, with no resident tion. d turkey with no opened on or urt containers with an 1/30/2024. s containing M & M candies entifying information and no				
	statt was responsib	le for cleaning out the pantry				

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NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION			•	4600 W	DDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC DEPOTE THE VINC DIFFERENCE TO SERVE THE PROPERTY OF		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	refrigerators.	R LSC IDENTIFYING INFORMATION		TAG	Daniel IV		DATE
	6. During an observe Activities Room or following was observe Activities Room or following was observe Activities Room or following was observe Activities Room or following was observe Activities Ac	oc bag of pizza sauce, dated oc bag of pizza sauce, dated outter with no opened on or use g of shredded cheese, dated had 4 burners and all 4 burners w the burners were dirty. had burnt on food debris. v on 12/5/2024 at 1:48 P.M., (AA) 8 indicated the left own away 7 days after e was no opened on date, the own away immediately. AA 8 usekeeping's responsibility to					
	and in the kitchene	ites.					
	indicated the facilit maintaining the kite equipment, but the	22 A.M., the Executive Director y did not have a policy for chen and the kitchen facility followed the Food and on's (FDA) Food Code as a					
	During an interview	v on 12/5/2024 at 10:30 A.M.,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355 A. BUILDING 00 B. WING 12/09/2024 STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE	
NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE	(X5)
WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN 46619	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	
CROSS-REFERENCED TO THE APPROPRIATE	MPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
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, cetling vents cleaned monthly, sweep and mop floors daily" 3.1-21(3) F 0880 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) During an observation of a dressing change, on 12/3/2024 at 10:12 A.M., LPN 2 removed the soiled dressing finom 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, LPN 2 had laid the supplies for the dressing change, and the clean dressing supplies. A record review was completed for Resident 42 on 12/4/204 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous The Control of the properties of the proper dressing change of proper dressing change o	/13/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155355	B. WING 12/09/2024				
	PROVIDER OR SUPPLIER			4600 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE	•	
WEST BE	END NURSING ANI	D REHABILITATION		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
		emur-distal, infection following			What measures will be put in	1	
	-	c obstructive pulmonary			place or what systemic		
		stolic heart failure, acquired			changes will be made to		
	_	above the knee and acquired above the knee, peripheral			ensure that the deficient practice does not recur:		
		d atherosclerosis of native			Nurses will be reeducated on		
	arteries of extremiti				Dressing Change Clean Tech	nigue	
	claudication, bilater				procedure. DNS/designee wil	-	
	Ź	_			observe nurse providing dress		
		on 12/3/2024 at 10:28 A.M.,			changes per skills validation		
		e should have washed her			check off by January 13, 2025	j.	
		removed the soiled dressing			DNS/Designee will conduct ro		
		e cleaned off the bedside table			during dressing changes to er		
	-	down for the dressing			proper infection control technic	ques	
	supplies.				are followed.		
	On 12/2/2024 at 2.4	10 D.M. the DON may ided a			How the corrective action(s)		
		18 P.M., the DON provided a sing Change Clean Technique			will be monitored to ensure to deficient practice will not	ine	
)", revised 10/2024, and			recur, i.e., what quality		
		was the one currently used			assurance program will be p	ut	
		policy indicated "8. Set up			into place:		
		ssing change supplies and			Ongoing compliance with this		
	other necessary equ	ipment. 10. Removed old			corrective action will be monitor	ored	
	•	esident and put directly in			through the facility Quality		
	•	. Remove gloves and discard.			Assurance and Performance		
	12. Perform hand hy	ygiene"			Improvement Program (QAPI)		
	2.1.10()				The ED/designee will be		
	3.1-18(a)				responsible for completing the		
					QAPI Audit Tool "Professional		
					standards of practice for dress changes" 3 x a week for 4 wee	-	
					weekly x 4 weeks, monthly for	I .	
					months and quarterly thereafte	I .	
					at least 2 quarters. If the		
					threshold of 90% is not met, a	n	
					action plan will be developed.		
					Findings will be submitted to t	he	
					QAPI Committee for review ar	nd	
					follow-up.		

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

PRINTED: 01/28/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED		
		155355	B. WI	B. WING			12/09/2024	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				4600 W	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE I BEND, IN 46619			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					By what date the systemic changes will be completed: January 14, 2025			

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