PRINTED: 01/24/2025

	T OF HEALTH AND HUI R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/06/2025	
NAME OF	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE		
WEST B	END NURSING AN	D REHABILITATION		SOUTH BEND, IN 46619			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEBLICIENTY)	
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	BETTELLINETY		DATE
Bldg		paredness Survey was	E 00	000	K000		
	conducted by the In accordance with 42 Survey Date: 01/06				The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth		
	Bend Nursing and I	.55355 275420 Preparedness survey, West Rehabilitation was found not in			in the statement of deficiencies of any violation of regulation. to the relative low scope and severity of this survey, the fact respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	of deficiencies, or of regulation. Due w scope and urvey, the facility uests a desk a post-survey	
	Requirements for M Participating Provide	nergency Preparedness Medicare and Medicaid Hers and Suppliers, 42 CFR has a capacity of 157 and had a time of this survey.					
E 0039 SS=F Bldg	Quality Review completed on 01/08/25 403.748(d)(2), 416.54(d)(2), 418.113(d)( EP Testing Requirements						
	failed to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a community	drills using the emergency C facility must do the annual full-scale exercise that	E 00	039	E0039  1. What corrective action will accomplished for those reside found to have been affected by deficient practice; Facility implemented Emergency Preparedness Plan on Januar 2025, from actual emergency event. Executive Director completed an after-action	ents by the ry 13,	02/04/2025

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

b. If the LTC facility experiences an actual natural

of the emergency plan, the LTC facility is exempt

or man-made emergency that requires activation

facility-based functional exercise.

TITLE

2. How other residents having the

potential to be affected by the

same deficient practice will be

analysis.

(X6) DATE

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<del></del>	COMPLE	
		155355	B. W	'ING		01/06/2	2025
NAME OF P	DOMDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			4600 W	/ WASHINGTON AVE		
WEST BE	END NURSING AN	D REHABILITATION		SOUTH	I BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ext required full-scale			identified and what corrective		
	community-based or individual, facility-based				action(s) will be taken; No		
	full-scale functional exercise for 1 year following				residents were affected; 57		
	the onset of the actual event.				residents and staff have the		
	(ii) Conduct an additional exercise that may				potential to be affected.		
	include, but is not limited to the following:				3. What measures will be put		
	a. A second full-scale exercise that is				place and what systemic chan	-	
	community-based or an individual, facility-based				will be made to ensure that the		
	functional exercise.				deficient practice does not rec		
	b. A mock disaster				Executive Director reeducated		
	_	se or workshop that is led by a			Maintenance Director regardir	ng	
	facilitator that includes a group discussion, using				the requirements to test the		
	a narrated, clinically relevant emergency scenario,				Emergency Preparedness Pla	ın	
	-	n statements, directed			twice per year. Maintenance		
		red questions designed to			Director or designee will ensu		
	challenge an emerg				two Emergency Preparedness		
		C facility's response to and			Plan testing is conducted year	rly,	
		ation of all drills, tabletop			consisting of either a		
		gency events, and revise the			community-based drill, tableto	-	
		gency plan, as needed in			exercise or record the experie	1	
	accordance with 42				of an actual natural or man-ma		
	-	ice could affect all residents,			emergency. Executive Directo	or	
	staff and visitors.				will ensure that after-action		
	TO 11				analysis is included for the		
	Findings include:				exercise or event.	<u>,</u>	
	D 1 1	e per en en a			4. How the corrective action(s	) WIII	
		view and interview with the			be monitored to ensure the		
		and Maintenance Director from			deficient practice will not recui	r,	
	-	m. on 01/06/25, the facility was			i.e., what quality assurance		
	_	documentation of a table-top			program will be put into place;		
		ale community-based exercise,			Ongoing compliance with this		
		ctional exercise or an actual			corrective action will be monite	orea	
		e emergency that required			through the facility Quality		
		nergency plan. Based on			Assurance and Performance		
		e of record review the			Improvement Program (QAPI)	1	
		for provided a document that a			Executive Director or designed		
		een completed; however, the			present Emergency Prepared		
		nclude information that facility			testing exercise or actual ever	าt(s)	
		ise or documented if the			to the QAPI Committee for		
	tacılıty's emergency	plan was revised as needed.			additional recommendations to	wo	

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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	<u></u>	COMPL	ETED
		155355	B. W	ING		01/06/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON AVE		
WEST BE	END NURSING ANI	D REHABILITATION		SOUTH BEND, IN 46619			
ı					. 52.45, 10010	111 40019	
(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' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		at time of record review the			times per year or as indicated.		
		or stated no other exercises			5. By what date the systemic	:11	
	were completed and no additional documentation was available.				changes for each deficiency w		
	was available.				be completed: February 4, 202	<u>2</u> 5.	
	This finding was rev	viewed with the Executive					
		enance Director at the time of					
	the exit conference.						
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 0	000	K000		
	Licensure Survey w	as conducted by the Indiana			The creation and submission o	of	
	-	th in accordance with 42 CFR			this plan of correction does no	t	
	483.90(a).				constitute an admission by this		
					provider of any conclusion set		
	Survey Date: 01/06/	/2025			in the statement of deficiencies	-	
	E '11' M 1 00	00246			of any violation of regulation.	Due	
	Facility Number: 00 Provider Number: 1				to the relative low scope and	II.	
	AIM Number: 1002				severity of this survey, the faci	lity	
	Alvi Nullibel, 1002	.73420			respectfully requests a desk review in lieu of a post-survey		
	At this Life Safety (	Code survey, West Bend			revisit on or after 2/4/2025.		
	-	litation was found not in			Tevisit off of after 2/4/2025.		
		equirements for Participation in					
	•	, 42 CFR Subpart 483.90(a),					
		re and the 2012 edition of the					
	•	etion Association (NFPA) 101,					
		SC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This facility consist	s of three connected					
		01, a two story, fully					
		g of Type II (222) construction;					
	•	story, fully sprinklered building					
		nstruction with a partial					
		ing 03, a one story, fully					
		g of Type V (111) construction.					
	The facility has a fir	re alarm system with smoke					

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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	01	COMPL	LETED
		155355	B. W	ING		01/06	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			/ WASHINGTON AVE		
WEST BE	END NURSING ANI	D REHABILITATION			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	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ridors, in spaces open to the					
	·	y-operated smoke detectors in					
		The building is fully protected					
		power generator. The facility					
		77 beds dually certified for					
		caid and had a census of 57 at					
	the time of this surv	ey.					
	Quality Review con	npleted on 01/08/25					
K 0321	NFPA 101						
SS=E Bldg. 01	Hazardous Areas	- Enclosure					
Diag. 01	Based on observation	on and interview, the facility	$ _{K0}$	221	K321		02/04/2025
		corridor door to 1 of 1	KU	321	1. What corrective action will be	ne	02/04/2023
		unoccupied resident room,			accomplished for those reside		
		in size with combustible			found to have been affected b		
		led with a self-closing device			deficient practice; Maintenanc	-	
		the door to automatically			Tech installed a self-closing d		
		the door frame. This deficient			on the unoccupied resident ro		
		t visitors, staff and residents			116 door being used as storag		
	_	npartments on the first floor.			with combustible supplies.	,	
					2. How other residents having	the	
	Findings include:				potential to be affected by the		
	Raced on observation	on and interview during tour			same deficient practice will be		
		the Maintenance Director from			identified and what corrective action(s) will be taken; No		
		m. on 01/06/25, the corridor			residents were affected.		
		n the first floor did not			Residents, staff and visitors ha	21/0	
		oor frame. This room was			the potential to be affected.	av <del>e</del>	
		ge of cardboard boxes and			3. What measures will be put	into	
	_	on interview at the time of			place and what systemic chan		
		intenance Director stated the			will be made to ensure that the		
	· · · · · · · · · · · · · · · · · · ·	ed for storage and was aware			deficient practice does not rec		
		nould have been installed on			Maintenance Tech conducted		
	the door.	iodia nave ocen motanea on			facility audit to validate doors	ч	
					properly close and latch for		
	This finding was re	viewed with the Executive			hazardous areas and storage		
		enance Director at the time of			rooms with combustible suppli	ies	
	the exit conference.	and the or			Executive Director reeducated		

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	OF CORRECTION	IDENTIFICATION NUMBER  155355	A. BUILDING B. WING	01	COMPLETED 01/06/2025
	PROVIDER OR SUPPLIER	D REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0324	3.1-19(b)			Maintenance Director on propodoor closure and latching for hazardous area and storage rooms with combustible suppli Maintenance Director will concrandom audits to validate door with self-closure properly latch 4. How the corrective action(s) 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 monitor through the facility Quality Assurance and Performance Improvement Program (QAPI) Maintenance Director/designe will be responsible for complete the QAPI Audit tool "Door Self-Closure with Secure Latch weekly for 4 weeks, and month thereafter for at least 5 months threshold of 90% is not met, a action plan will be submitted to the QAPI Committee for review are follow up.  5. By what date the systemic changes for each deficiency we be completed: February 4, 202	es. duct rs n. ) will r;  pred  . The e ting h'' hly s. If n ne nd
SS=E Bldg. 01	Cooking Facilities	on and intermitary the College	W 0224	LV204	00/04/2025
	failed to ensure staf the UL 300 hood fin kitchen. NFPA 96,	on and interview, the facility if were instructed in the use of the suppression system in 1 of 1 Standard for Ventilation otection of Commercial	K 0324	K324  1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; Executive	nts

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED
		155355	B. WING		01/06/2025
	PROVIDER OR SUPPLIEI	REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE I BEND, IN 46619	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	instruction shall be regarding the prope	s, Section 10.5.7 states provided to employees or use of portable fire		Director immediately reeducated Culinary Cook on use of the hard fire suppression system and	
	fire-extinguishing of	he manual activation of equipment. Section 11.1.4 states		portable fire extinguishers.  2. How other residents having	
	extinguishing syste conspicuously in th	nually operating the fire m shall be posted le kitchen and shall be loyees by management. This		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No	
	_	ould affect kitchen staff.		residents were affected. Only kitchen staff have the potential be affected.	
		on and interview during tour		What measures will be put place and what systemic char	
	1:10 p.m. to 3:30 p	the Maintenance Director from .m. on 01/06/25, the kitchen was		will be made to ensure that the deficient practice does not rec	cur;
	interview, a kitcher	. 300 hood system. Based on a staff culinary cook was asked if there was a fire underneath		Maintenance Director or design will educate culinary staff on the procedure to use the hood fire	he
	the hood. She replie	ed she would use the pointing to the K Class fire		suppression system and porta fire extinguishers on or before	able
	would be the first the	vas asked a second time what hing she would do, and she		2/3/2025. Executive Director of designee will conduct random	
	indicate manually a	ne answer. She failed to activating the Kitchen hood fire pull station. When the		audits to validate staff understanding of procedure to the hood fire suppression syst	
	surveyor pointed to	the pull station for the fire and asked if she knew what		and portable fire extinguishers 4. How the corrective action(s	S.
		e replied that it activates the d she did not know of any		be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place	
		viewed with the Executive enance Director at the time of		Ongoing compliance with this corrective action will be monit through the facility Quality Assurance and Performance	
	3.1-19(b)			Improvement Program (QAPI) Maintenance Director/designe will be responsible for comple	ee ting

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDI	PLE CONSTRUCTION ING <u>0</u> 1	î î	E SURVEY PLETED
AND FLAIN	or connection	155355	B. WING			6/2025
NAME OF I	PROVIDER OR SUPPLIEI	3		REET ADDRESS, CITY, STATE, ZI 600 W WASHINGTON AVE		
WEST B	END NURSING AN	D REHABILITATION	S	OUTH BEND, IN 46619		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	IE PRE	PROVIDER'S PLAN OF O		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TA	CROSS-REFERENCED TO TH	HE APPROPRIATE	DATE
K 0355 SS=F Bldg. 01	failed to ensure 20 were installed in ac NFPA 10, Standard 2010 Edition, Secti extinguishers havin exceeding 40 lb. sh of the fire extinguis above the floor. The affect all residents, Findings include:  Based on observation of the facility with 1:10 p.m. to 3:30 p extinguishers locate mounted with the to between 5 feet and on interview at the Maintenance Direct the extinguishers we same locations with mounted in the main	on and interview, the facility of 23 portable fire extinguishers cordance with NFPA 10.  If for Portable Fire Extinguishers, on 6.1.3.8.1 states fire ag a gross weight not all be installed so that the top sher is not more than five feet his deficient practice could	K 0355	Suppression System weeks, and monthly at least 5 months. If 90% is not met, an a be developed. Finding submitted to the QAI for review and follows 5. By what date the schanges for each deside be completed: February 1. What corrective a accomplished for the found to have been a deficient practice; The extinguisher located maintenance shop we and reinstalled in action NFPA 10, Standard Fire Extinguishers, 2. How other resider potential to be affect same deficient practice dentified and what continued action (s) will be taked residents were affect 3. What measures we place and what system will be made to ensure deficient practice do recur; Executive Director requirements on por extinguisher location accordance with NF Standard for Portables.	thereafter for threshold of action plan will angs will be PI Committee vup. systemic efficiency will larry 4, 2025.  In the contained by the angle portable fire in the vas lowered cordance with for Portable 2010 Edition. The having the effect will be corrective en; No sted. Vill be put into emic changes are that the es not ector educated or on table fire in in PA 10,	02/04/2025

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/24/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/06/2025	
	PROVIDER OR SUPPLIEF	R D REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP COD / WASHINGTON AVE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		viewed with the Executive enance Director at the time of		Extinguishers, 2010 Edition. Maintenance Director conductor an audit of all portable extinguishers to ensure proper location in accordance with NF 10, Standard for Portable Fire Extinguishers, 2010 Edition. L Safety Supervisor supports the extinguishers located in the full recessed wall cabinets to remain place; these fire extinguisher are easily accessible in an everof a fire.  4. How the corrective action(s) 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 monitor through the facility Quality Assurance and Performance Improvement Program (QAPI). Maintenance Director/designer will be responsible for complet the QAPI Audit tool "Fire Extinguisher Placement" week for 4 weeks, and monthly thereafter for at least 5 months the threshold of 90% is not me an action plan will be developed Findings will be submitted to the QAPI Committee for review and follow up.  5. By what date the systemic changes for each deficiency where completed: February 4, 20.	FPA  ife efire lly eain ers ent  will eight will eight
K 0511	NFPA 101				

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Utilities - Gas and Electric

SS=E

Event ID:

N8UH21

Facility ID: 000246

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155355	B. W	NG		01/06/	2025
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	S.			/ WASHINGTON AVE		
WEST DI	END NI IDRING ANI	D REHABILITATION			BEND, IN 46619		
WESID	רווא אווופטטאו מאי	DICHADILITATION		30016			
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01							
		on and interview, the facility	K 0	511	K511		02/04/2025
		f 1 ground fault circuit			What corrective action will be a contractive action will be a contractive action.		
		n the clean utility closet on the			accomplished for those reside		
	-	unit was properly maintained			found to have been affected b	-	
		st electric shock. NFPA 70,			deficient practice; Maintenanc	е	
		at 210.8 Ground-Fault			Tech installed a new GCFI		
	*	Protection for Personnel,			electrical receptacle in the clea	an	
		circuit-interruption for			utility closet on MF.		
		provided as required in 210.8.			2. How other residents having	the	
	This deficient practi	ice could affect staff only.			potential to be affected by the		
					same deficient practice will be		
	Findings include:				identified and what corrective		
					action(s) will be taken; No		
		on and interview during tour			residents were affected. Only		
	_	the Maintenance Director from			have the potential to be affect		
		m. on $01/06/25$ , when the GFCI			3. What measures will be put i		
	-	n clean utility closet on the			place and what systemic chan	-	
	-	hall was tested with a GFCI			will be made to ensure that the		
		eptacle failed to trip and did not			deficient practice does not rec	ur;	
		circuit. When measured the			Executive Director validated		
	_	nches from the center of a sink			installation of a new GCFI		
		erview at the time of			electrical receptable. Executiv		
		intenance Director agreed the			Director reeducated Maintena	nce	
		tacle did not properly work			Director on requirements for		
		tester was indicating a			properly GFCI electrical		
		wiring issue. The Maintenance			receptable. Maintenance		
		recently an electrical			Manager/designee will conduct		
	contractor had insta	lled the receptacle.			random audits of GCFI electric	cal	
	mi c i	t did a m			receptacles to ensure proper		
	_	viewed with the Executive			functioning.	<b>.</b>	
		enance Director at the time of			4. How the corrective action(s	) WIII	
	the exit conference.				be monitored to ensure the	_	
	2.1.10(1)				deficient practice will not recui	,	
	3.1-19(b)				i.e., what quality assurance		
					program will be put into place;		
					Ongoing compliance with this		
					corrective action will be monito	orea	
					through the facility Quality		
			l		Assurance and Performance		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	r í	JILDING	onstruction  01	(X3) DATE COMPL <b>01/06</b> /	ETED
	ROVIDER OR SUPPLIER	D REHABILITATION		4600 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
K 0000					Improvement Program (QAPI) Maintenance Director/designe will be responsible for complet the QAPI Audit tool "GCFI" we for 4 weeks, and monthly thereafter for at least 5 months threshold of 90% is not met, a action plan will be developed. Findings will be submitted to th QAPI Committee for review ar follow up. 5. By what date the systemic changes for each deficiency w be completed: February 4, 202	e ing ekly s. If n ne id	
Bldg. 02	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 01/06/ Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety O Nursing and Rehabic compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L) Health Care Occupa	20246 55355 75420 Code survey, West Bend litation was found not in quirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing uncies and 410 IAC 16.2.	K 0	000	K000  The creation and submission of this plan of correction does no constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. It to the relative low scope and severity of this survey, the facing respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	t s forth s, or Due	
	•	s of three connected 01, a two story, fully					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 01/06/2025
	PROVIDER OR SUPPLIER	D REHABILITATION	4600 V	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=F Bldg. 02	Building 02, a one so of Type V (000) conbasement and Build sprinklered building The facility has a findetection in the corrocorridors and batter all resident rooms. The survey of the facility has a capacity of 15 Medicare and	inguishers  on and interview, the facility of 23 portable fire extinguishers cordance with NFPA 10. for Portable Fire Extinguishers, on 6.1.3.8.1 states fire g a gross weight not all be installed so that the top her is not more than five feet is deficient practice could	K 0355	K355  1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; The portable extinguisher located in the maintenance shop was lowere and reinstalled in accordance NFPA 10, Standard for Portable Fire Extinguishers, 2010 Editive 2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected.  3. What measures will be put place and what systemic charwill be made to ensure that the deficient practice does not recur; Executive Director educ	ents by the e fire ed with ble on. I the e into nges e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>		COMPLETED	
		155355	B. W	ING		01/06/	/2025
NAME OF B	DROVIDED OF CUIPN IEE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF			4600 W	/ WASHINGTON AVE		
WEST BE	END NURSING AN	D REHABILITATION		SOUTH	HBEND, 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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
	_	ere always mounted in the			Maintenance Director on		
	same locations with the exception of one he mounted in the maintenance shop that was also				requirements on portable fire		
		-			extinguisher location in accordance with NFPA 10,		
	mounted between 5 feet and 6 feet above the floor.				Standard for Portable Fire		
	11001.				Extinguishers, 2010 Edition.		
	This finding was re	viewed with the Executive			Maintenance Director conduct	ted	
	_	enance Director at the time of			an audit of all portable	<del></del>	
	the exit conference.				extinguishers to ensure prope	r	
					location in accordance with NI		
	3.1-19(b)				10, Standard for Portable Fire		
					Extinguishers, 2010 Edition. I	₋ife	
					Safety Supervisor supports th	e fire	
					extinguishers located in the fu	-	
					recessed wall cabinets to rem		
					in place; these fire extinguishe		
					are easily accessible in an eve	ent	
					of a fire.	<b>.</b>	
					4. How the corrective action(s	) Will	
					be monitored to ensure the	_	
					deficient practice will not recui	Γ,	
					i.e., what quality assurance program will be put into place;		
					Ongoing compliance with this		
					corrective action will be monite	ored	
					through the facility Quality	J. 04	
					Assurance and Performance		
					Improvement Program (QAPI)	. The	
					Maintenance Director/designe		
					will be responsible for comple		
					the QAPI Audit tool "Fire		
					Extinguisher Placement" weel	kly	
					for 4 weeks, and monthly		
					thereafter for at least 5 month		
					the threshold of 90% is not me	,	
					an action plan will be develope		
					Findings will be submitted to t		
					QAPI Committee for review ar	nd	
					follow up.		
	I		- 1		5 By what date the systemic		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155355			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/06/2025	
	PROVIDER OR SUPPLIE END NURSING AN	R ID REHABILITATION	4600 V	ADDRESS, CITY, STATE, ZIP COD V WASHINGTON AVE H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				changes for each deficiency w be completed: February 4, 20		
K 0000						
Bldg. 03	Licensure Survey v Department of Hea 483.90(a).  Survey Date: 01/06  Facility Number: 0 Provider Number: 100  At this Life Safety Nursing and Rehab compliance with R Medicare/Medicaic Life Safety from Fi National Fire Prote	00246 155355	K 0000	K000  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. It to the relative low scope and severity of this survey, the fact respectfully requests a desk review in lieu of a post-survey revisit on or after 2/4/2025.	t s forth s, or Due	
	Health Care Occup  This facility consis buildings: Building sprinklered buildin Building 02, a one of Type V (000) co basement and Build sprinklered buildin The facility has a fidetection in the cor corridors and batter all resident rooms. by a 400-kW diese has a capacity of 1:	ts of three connected (01, a two story, fully g of Type II (222) construction; story, fully sprinklered building onstruction with a partial ding 03, a one story, fully g of Type V (111) construction. ire alarm system with smoke tridors, in spaces open to the ry-operated smoke detectors in The building is fully protected I power generator. The facility 57 beds dually certified for icaid and had a census of 57 at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	A. BUILDING <u>03</u> C		COMPI	x3) date survey Completed 01/06/2025			
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 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  the time of this survey.  Ouglity Payions completed on 01/08/25			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
mo				1710			DATE		
K 0293 SS=E Bldg. 03	=E Exit Signage								
	Based on observation and interview, the facility failed to ensure 3 of 3 doors to the outside of the facility in the "Tunnel" area were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect all residents, staff and visitors in the "Tunnel" corridor.  Findings include:  Based on observation and interview during tour of the facility with the Maintenance Director from 1:10 p.m. to 3:30 p.m. on 01/06/25, the "Tunnel" corridor contained 3 exterior doors which could be mistaken as an exit. 2 of 3 doors lead to an enclosed courtyard with no direct access to a public way. 1 of 3 doors led to an exterior area that was fenced in and had a dense row of evergreen trees approximately 6 feet outside the door and extending approximately 20 feet to the left and right of the door. Immediately outside the door was a concrete pad approximately 4 feet by 4 feet		K 0	293	1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; Maintenance Director installed "no exit" sign on the three "Tunnel" corridor doors to provide a clear direct of no means egress.  2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected; 30 residents and staff have the potential to be affected.  3. What measures will be put place and what systemic char will be made to ensure that the deficient practice does not receive active Director validated "rection of no path of egress. Executive Director/designee we ducate staff on "no exit" sign placed on "Tunnel" corridor exit doors to provide clear direction of means egress on or before 2/3/2025. Maintenance Manager/designee will conduct andom audits of "no exit" sign on exit doors with no means of	ents by the se hage exit cion the into nges e cur; no vill age kit n of e ct nage	02/04/2025		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  03			(X3) DATE SURVEY COMPLETED		
155355		B. Wl	B. WING			01/06/2025		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 4600 W WASHINGTON AVE SOUTH 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		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG DEFICIENCY)			DATE	
	· ·	yard were not exits but 1 door exit.			egress for visibility.			
	could be used as an exit.  This finding was reviewed with the Executive Director and Maintenance Director at the time of the exit conference.  3.1-19(b)			4. 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 Maintenance Director/designee will be responsible for completing the QAPI Audit tool "No Exit Signage" weekly for 4 weeks, and monthly thereafter for at least 5 months. If 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.  5. By what date the systemic changes for each deficiency will be completed: February 4, 2024.				
K 0355 SS=F Portable Fire Extinguishers Bldg. 03								
	failed to ensure 20 of were installed in accommod NFPA 10, Standard 2010 Edition, Section extinguishers having exceeding 40 lb. should be should b	on and interview, the facility of 23 portable fire extinguishers cordance with NFPA 10. for Portable Fire Extinguishers, on 6.1.3.8.1 states fire g a gross weight not all be installed so that the top her is not more than five feet is deficient practice could staff and visitors.	K 0	355	1. What corrective action will be accomplished for those reside found to have been affected be deficient practice; The portable extinguisher located in the maintenance shop was lowered and reinstalled in accordance NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition 2. How other residents having	nts y the e fire ed with ole	02/04/2025	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>03</u>		COMPLETED		
		155355	B. WING		01/06/	2025	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			WASHINGTON AVE		
WESTR	END NHRSING AN	D REHABILITATION			I BEND, IN 46619		
VVLO1 DI	LIAD MOROING AIN	D REHADILITATION		550111	, DEND, IN 70018		
(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	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				potential to be affected by the		
					same deficient practice will be	!	
		on and interview during tour			identified and what corrective		
		the Maintenance Director from			action(s) will be taken; No		
		m. on 01/06/25, 20 portable fire		residents were affected.			
	-	ed throughout the facility were	1		3. What measures will be put i		
		op of the extinguishers			place and what systemic chan	•	
		6 feet above the floor. Based			will be made to ensure that the	е	
		time of observation, the	1		deficient practice does not		
		for stated the fire extinguishers			recur; Executive Director educ	cated	
	_	ere always mounted in the	1		Maintenance Director on		
		the exception of one he			requirements on portable fire		
		ntenance shop that was also			extinguisher location in		
	mounted between 5 feet and 6 feet above the			accordance with NFPA 10,			
	floor.				Standard for Portable Fire		
					Extinguishers, 2010 Edition.		
	This finding was reviewed with the Executive				Maintenance Director conduct	ed	
	Director and Maintenance Director at the time of				an audit of all portable		
	the exit conference.				extinguishers to ensure prope		
					location in accordance with NI		
	3.1-19(b)				10, Standard for Portable Fire		
					Extinguishers, 2010 Edition. L		
					Safety Supervisor supports the		
			1		extinguishers located in the fu	-	
					recessed wall cabinets to rem		
					in place; these fire extinguishe		
					are easily accessible in an eve	ent	
					of a fire.	\iII	
					4. How the corrective action(s	) WIII	
			be monitored to ensure the				
					deficient practice will not recui	,	
					i.e., what quality assurance program will be put into place;		
					Ongoing compliance with this		
					corrective action will be monitor	ored	
					through the facility Quality	Ji <del>C</del> u	
					Assurance and Performance		
					Improvement Program (QAPI)	The	
					Maintenance Director/designe		
				will be responsible for complete			
					will be responsible for complet	uriy	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155355	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD		03	(X3) DATE SURVEY COMPLETED 01/06/2025		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE	
					the QAPI Audit tool "Fire Extinguisher Placement" week for 4 weeks, and monthly thereafter for at least 5 months the threshold of 90% is not me an action plan will be develope Findings will be submitted to the QAPI Committee for review ar follow up.  5. By what date the systemic changes for each deficiency we be completed: February 4, 20	s. If et, ed. ne nd		

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