PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01, 02, 03	(X3) DATE SURVEY COMPLETED	
155355		B. WING	B. WING		R 02/14/2025		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			14/2025
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 0	{E 000}			
{K 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 01/06/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/14/2025 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420 At this PSR survey, West Bend Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 157 and had a census of 63 at the time of this survey. Quality Review completed on 02/19/25 INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 01/06/2025 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 02/14/2025 Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420		{K 0	000)			
	Rehabilitation was fo	West Bend Nursing and und in compliance with					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 02 , 03			(X3) DATE SURVEY COMPLETED	
		155355	B. WING			R 02/14/2025		
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			14/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{K 000}	Life Safety from Fire National Fire Protecti Life Safety Code (LSG Health Care Occupar This facility consists of Building 01, a two sto of Type II (222) const one-story, fully sprink (000) construction with Building 03, a one-story of Type V (111) const	rticipation in 12 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing noise and 410 IAC 16.2. of three connected buildings: bry, fully sprinklered building rruction; Building 02, a chered building of Type V th a partial basement and bry, fully sprinklered building rruction. The facility has a fire	{K 0	00}				
{K 000}	battery-operated smorooms. The building is 400-kW diesel power capacity of 157 beds and Medicaid and har of this survey. Quality Review comp INITIAL COMMENTS A Post Survey Revis Code Recertification at that exited on 01/06/2 Indiana Department of	open to the corridors and obke detectors in all resident is fully protected by a generator. The facility has a dually certified for Medicare id a census of 63 at the time detected on 02/19/25 it (PSR) to the Life Safety and State Licensure Survey 2025 was conducted by the of Health in accordance 42	{K 0	00}				
	CFR Subpart 483.90(Survey Date: 02/14/2 Facility Number: 0002 Provider Number: 150275 AIM Number: 100275	025 246 5355						

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01, 02, 03		(X3) DATE SURVEY COMPLETED	
	155355		B. WING _	B. WING		R 02/14/2025	
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{K 000}	Rehabilitation was for Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire a National Fire Protectic Life Safety Code (LSG Health Care Occupar This facility consists of Building 01, a two storof Type II (222) construction with Building 03, a one-story fully sprink (000) construction with Building	Vest Bend Nursing and and in compliance with ticipation in 2 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing acies and 410 IAC 16.2. If three connected buildings: ry, fully sprinklered building ruction; Building 02, a lered building of Type V h a partial basement and bry, fully sprinklered building ruction. The facility has a fire tooke detection in the pen to the corridors and ke detectors in all resident	{K 0	00}			
{K 000}	Code Recertification a that exited on 01/06/2	t (PSR) to the Life Safety and State Licensure Survey 2025 was conducted by the of Health in accordance 42 a).	{K 0	00}			

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01, 02, 03		(X3) DATE SURVEY COMPLETED		
	455255		B. WING			R		
NAME OF PROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, STATE, ZIP CODE	02/	14/2025	
WEST BEND NURSING AND REHABILITATION				4600 W WASHINGTON AVE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{K 000}	Rehabilitation was for Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire National Fire Protecti Life Safety Code (LSt Health Care Occupar This facility consists of Building 01, a two stor Type II (222) const one-story, fully sprink (000) construction with Building 03, a one-story fully sprink (111) const alarm system with sm corridors, in spaces of battery-operated smorrooms. The building is 400-kW diesel power capacity of 157 beds	Vest Bend Nursing and und in compliance with ricipation in 12 CFR Subpart 483.90(a), and the 2012 edition of the on Association (NFPA) 101, C), Chapter 19, Existing ncies and 410 IAC 16.2. of three connected buildings: bry, fully sprinklered building ruction; Building 02, a clered building of Type V that a partial basement and bry, fully sprinklered building ruction. The facility has a fire noke detection in the open to the corridors and ske detectors in all resident is fully protected by a generator. The facility has a dually certified for Medicare dia census of 63 at the time	{K 0	00}				