STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/03/21 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Emergency Preparedness survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 111 certified beds. At the time of the survey, the census was 55 . Quality Review completed on 06/11/21	E 0000		
E 0020 SS=F Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b) (3). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan (EPP) with the Administrator on 06/03/21 at 11:33 a.m., there was no documentation to indicate the identification of evacuation locations during an evacuation. Based on an interview during the exit conference with the Administrator it was stated the EPP would have to be updated to include identification of evacuation locations.	E 0020	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents and staff have the potential to be affected by this alleged deficient practice. The Emergency Preparedness binders were updated under Section D of the Emergency Preparedness	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Manuals (EPM) for full building evacuation. Staff have been educated on the revision of the EMP. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: Emergency Preparedness Binders have been updated to include the evacuation locations. Binders will remain on annual reviews and annual staff training on the EPM will continue on-going. Review and training results will be presented to the QAPI committee for any revision. **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:** Training and EMP binder education results will be presented to the QAPI committee annually for review and recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan with the Administrator during record review at 11:45 a.m. on 06/03/21, documentation of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on interview at the time of record review, the Administrator agreed documentation of arrangements with other facilities was not available for review at the time of the survey.	E 0025	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Mutual aide agreements have been sent to area facilities and facility will place them in the EPM when returned with signatures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** LTC	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			transfer agreements are placed in the proper section of the Emergency Preparedness Manual (EPM) (Appendix B). Facility management was educated on the EPM binder to include the location of Mutual Aide forms with other LTC facilities. Binders will remain on annual reviews and annual staff training on the EPM will continue on-going. Review and training results will be presented to the QAPI committee for any revision. **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:** Training and EMP binder education results will be presented to the QAPI committee annually for review and recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of Emergency Preparedness Policy (EPP) on 06/03/21 at 11:55 a.m. with the Administrator, the facility lacked documentation of a full-scale community based exercise over the past year. Nor has the facility documented an experienced actual natural or man-made emergency that required activation of the emergency plan, which would exempt the facility from engaging its next required full-scale in a community based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. Based on interview during the exit conference the Administrator stated a full-scale community based exercise had not been done for the past year nor any other emergency exercises which would involve the implementation of the EPP.		**practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility has completed a tabletop exercise and will complete another exercise/drill that will activate the use of the Emergency Preparedness Manual within the year. Documentation of the facility disaster exercise/training was placed in the Emergency Preparedness binder for future reference. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/Designee will schedule 1 annual tabletop exercise or community-based exercise plan in coordination with District 2 Healthcare Coalition and 1 disaster drill that will require activating use of the Emergency Preparedness Manual each year going forward. QAPI committee and facility management team will be advised of scheduled exercises and review completed documentation for recommendations. **How the corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING -- B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice will not recur, i.e., what quality assurance program will be put into place: Completed documentation of any exercises will be reviewed by the QAPI committee for recommendations. Exercises/drills will be scheduled with the QAPI committee/agenda to ensure completion and review. **By what date the systemic changes will be completed:** 6/25/2021	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/03/21 Facility Number: 013420 Provider Number: 155831 AIM Number: 201293620 At this Life Safety Code survey, Briarcliff Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with smoke detection in the corridors, all areas open to the corridor and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 111 and had a census of 55 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/11/21			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to provide access to means of egress for 1 of 1 Courtyard exit discharge observed with a	K 0222	*This plan of Correction is the facility's credible allegation of compliance.*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	combination lock installed on the inside in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2, 19.2.2.2 and 19.2.2.2.4. This deficient practice could affect any resident, staff or visitor in the Dining room. Findings include: Based on observation on 06/03/21 at 2:11 p.m. with the Administrator and Maintenance Director (MD), the Courtyard gate outside the Dining room was equipped with a combination lock on the inside. Based on interview at the time observation with the Administrator and MD, the QMA and the CNA were asked if they knew the combination of the lock on the Courtyard gate and both staff said they did not know nor did anyone else. The Administrator added, this lock had just been installed and there hadn't been enough time to inform staff of the combination. This was discussed with the Administrator during the exit conference. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents/staff who would need to evacuate the facility through a courtyard gate have the potential to be affected by this alleged deficient practice. Staff has been in-serviced on the courtyard secure system of combination padlocks on exterior gates in the event use of the exit gates would be required. The Padlock codes are also noted on house number signs located in the courtyards. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			practice does not recur: Staff will be educated on the process of entering the codes to open the padlocks in event of an emergency. Continued education will be provided in the event of need to change padlock codes and reviewed in the annual Emergency Preparedness review. Maintenance Director/designee will interview a minimum of 5 staff weekly x 8 weeks to ensure staff know either the correct code or where to locate the code, this will include agency and contracted staff. **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:** Maintenance Director/designee will present to the QAPI committee results of the audits for 2 months for substantial compliance. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic changes will be completed:** 6/25/2021	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility	K 0225	*This plan of Correction is the*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to provide a continuous protected path of travel to an exit discharge for 1 of 1 stairwells in accordance with LSC sections 7.2.3.5. LSC 7.2.3.5.1 requires every smoke proof enclosure shall discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway. Such exit passageways shall be without openings other than the entrance from the smoke proof enclosure and the door to the outside yard, court, or public way. The exit passageway shall be separated from the remainder of the building by a two hour fire resistance rating. This deficient practice affects all residents, staff and visitors. Findings include: Based on observation on 06/03/21 at 2:46 p.m. with the Administrator and Maintenance Director (MD), the basement stairwell door had a fire resistance rating label, but it was painted over and the fire resistance rating could not be determined. Based on interview at the time of the observation, the MD acknowledged the fire resistance rated label was painted over and he could not ascertain its fire rating. This was discussed with the Administrator during the exit conference. 3.1-19(b)		*facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** This alleged deficient practice could affect any staff/ resident located in the area of stairwell. The fire rating tag was cleared of any paint and can be viewed for rating. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff will be educated on the importance of not painting over any fire rating located on smoke and fire doors. When	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			painting/repairing any doors in the future, notation of any tags not clearly visible should be reported to the supervisor/administrator timely. Inspection of fire/smoke doors throughout the populated areas of facility was completed with no other findings of non-compliance. **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:** Fire rating tag inspections will be added to the annual door inspection report. Any findings of non-compliance will be corrected immediately. Results of this annual report will be presented to QAPI for any recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 1. Based on observation and interview the facility failed to maintain exit access routes free and clear of obstructions for 1 of 9 corridor exit access in	K 0232	*This plan of Correction is the facility's credible allegation of compliance.*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordance with the requirements of NFPA 101, 2012 edition, sections 19.2, 19.2.1, 7.1.10 and 7.1.10.1. This deficient practice could affect any resident, staff or visitor exiting through the 100 Vacant hall. Findings include: Based on observation on 06/03/21 at 2:35 p.m. with the Administrator and Maintenance Director (MD) there was two resident beds, crates, and pallets full of boxes stored in the corridor of 100 Vacant hall reducing the eight foot width of the corridor to 54 inches. Based on interview concurrent with the observations the Administrator stated the 100 hall was vacant and was not required to be surveyed. This was discussed with Administrator during the exit conference. 3.1-19(b) 2. Based on observation, the facility failed to meet the clear width requirement for 1 of 9 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The corridor to the unpopulated area located in the closed 100-200 unit was cleared of any obstructions. The resident chairs located near the nurse's station on the 700 unit were removed from the corridor. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Any residents/ staff could be affected by this alleged deficient practice. The corridor to the unpopulated area located in the closed 100-200 unit was cleared of any obstructions. The resident chairs located near the nurse's station on the 700 unit were removed from the corridor. Staff have been educated on the importance of ensuring all exit corridors are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect any resident, visitor or staff using the 700 hall exit. Findings include: Based on observation on 06/03/21 at 4:00 p.m. with the Administrator and Maintenance Director (MD) the 700 hall directly across from the Nursing station had three chairs unsecured in the corridor which measured eight feet wide limiting the corridor width to less than five feet. Based on interview at the time of the observation and measurement with the Administrator and MD it was acknowledged the chairs were not secured and promptly moved the chairs. This finding was discussed with the Administrator at the exit conference. 3.1-19(b)		always clear of obstacles. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been educated on the importance of ensuring all exit corridors are always clear of obstacles. Maintenance Director/designee will do observations a minimum of 5 times weekly x 8 weeks to ensure exit corridors are clear of any obstacles. Summary of these observations will be presented to the QAPI committee. **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:** Maintenance Director/designee will present to the QAPI committee results of the audits for 2 months for substantial compliance. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic changes will be completed:** 6/25/2021	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 4 of 4 battery backup lights were tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 06/03/21 at 12:20 p.m. with the Maintenance Director (MD), the Battery Backup Light Test Log for 2020 to 2021 did not specify the time the lights were tested for either the monthly or annual tests conducted over the past year. Based on an interview at the time of record review, the MD indicated the lack of documentation of time in the Battery Backup Light Test log. This was reviewed with the administrator during the exit conference. 3.1-19(b)	K 0291	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The battery backup light test log has been modified to show the time of the test. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The testing log was modified to be able to log the times of tests. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Testing	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			of emergency lighting battery backup will continue as scheduled for compliance. The log has been revised so time of test can be included on the report. Maintenance staff have been educated on the revised log and completion of log. **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:** Test logs will be reviewed monthly by the maintenance director and Administrator/designee for compliance. Any findings of non-compliance will be reviewed by the QAPI committee for recommendations needed to maintain compliance. **By what date the systemic changes will be completed:** 6/25/2021	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 1. Based on record review and interview; the facility failed to install exit signage in 1 of 9	K 0293	*This plan of Correction is the facility's credible allegation of*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	corridors in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 25 residents, visitors, and staff. Findings include: Based on observation on 06/03/21 at 3:22 p.m. with the Administrator and Maintenance Director (MD), the horizontal exit smoke/fire doors on Service hall were not provided with an exit sign on the east side of the smoke wall to indicate a pathway to an exit. Based on interview at the time of observation, the MS acknowledged there were no directional exit signs on both sides of the smoke wall as required. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 9 corridor doors leading to the outside of the facility 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 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** This is an un-occupied area of facility closed to residents. Staff who are in the un-occupied area have the potential to be affected by this alleged deficient practice. A bi-directional lighted exit sign has been ordered and will be installed to meet compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An inspection of exit corridors in the populated areas of facility found no	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	existing sign. This deficient practice could affect 20 residents, staff, and visitors. Findings include: Based on observation on 06/03/21 at 3:10 p.m. with the Administrator and Maintenance Director (MD), the door to the 100 vacant hall which leads to the outside of the facility does not have any exit signage, but can be interpreted as an exit access, however, the Administrator does not want occupants to exit through 100 hall. Based on interview with the Administrator concurrent with the observation it was acknowledged the 100 vacant hall corridor was not to be used as an exit event though it was a legitimate exit and acknowledged the door was not provided with a NO EXIT sign. He further stated this was a vacant hall and should not be surveyed. 3.1-19(b)		further areas of non-compliance of exit signs. **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:** The Maintenance Director/designee will report to the QAPI committee when proper placement of exit light is completed. As this one area of non-compliance will be corrected, no further reporting to the QAPI committee will be required. **By what date the systemic changes will be completed:** 6/25/2021	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 6 of 7 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided with a self-closing device. This deficient practice could affect residents in the adjacent smoke compartment as well as staff on 100 vacant hall and Supply room. Findings include: Based on observations on 06/03/21 during the tour between 12:32 p.m. to 3:35 p.m. with the Administrator and Maintenance Director (MD), the following areas were either not provided with corridor doors or were not equipped with a self-closing device: a. 100 vacant hall in room #4 stored 16 cardboard boxes and no corridor door was installed. b. 100 vacant hall in room #7 stored 25 cardboard boxes and no corridor door was installed. c. 100 vacant hall in room #12 stored "too many to count" TMC cardboard boxes and no corridor	K 0321	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the**	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	door was installed. d. Central supply on 200 vacant Service hall stored 47 cardboard boxes in room #1 and no corridor door was installed. e. Central supply on 200 vacant Service hall stored 39 cardboard boxes in room #2 was not equipped with a closure on the corridor door. f. Supply room adjacent to dining room stored 21 cardboard boxes and was not equipped with a closure on the corridor door. Based on interview at the time of observations with the Administrator and MD it was stated the 100 hall and 200 hall were vacant and should not be subject to inspection and was not required to abide by LSC regulations. The Administrator further added the Supply room would have a self-closing device installed and also acknowledged the areas were over 50 square feet. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to enclose 1 of 1 hot oil popcorn poppers in a room with corridor doors equipped with a self-closing device. This deficient practice could affect all residents, staff, and visitors in the Dining room. Findings include: Based on observation on 06/03/21 at 4:16 p.m. with the Administrator and Maintenance Director (MD), a hot oil popcorn popper was stored in the Activities office. It was explained to the Administrator when in use this creates a hazardous environment and requires any corridor door to be equipped with a self-closing device. Based on interview at the time of observation, the		**potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken**: Residents will not be affected by the alleged deficient practice on the unpopulated area of facility. Only residents on the 700-800 unit have the potential to be affected by the storage of the popcorn popper in the activity office. Activity staff have been educated on the proper storage of items in a room with an automatic closure and importance of using the popcorn popper only in areas in the facility that have an automatic closure on corridor doors. Stored items considered combustible on the unpopulated 100-200 unit will be in rooms with a door installed to the corridor. These corridors remain locked and unpopulated. Central supply storage area is noted as already having an automatic closure in place as was demonstrated by the surveyor during observation rounds of survey. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Other storage areas within the populated area of facility were inspected and no other findings of non-compliance were noted. 1. · a-f- this area remains	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator stated the popcorn machine was taken to the Dining room when in use and the Dining room was open to the corridor. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		locked and unpopulated. A dumpster has been ordered to dispose of items no longer in use for facility. Any items deemed as combustible will be placed in rooms with a closure installed. Noncombustible items will be stored in rooms, not in corridors. Corridors will remain clear. 2. · A closure device was installed on the activity office on 700-800 unit. Supervisors were educated on the safety of storing any combustible items in rooms with doors equipped with closure devices. Activity staff were educated on the locations that the popcorn machine can be used safely. Maintenance Director/designee will observe storage areas to ensure areas over 50 sq. ft. and have combustibles in them are equipped with a functioning closure device and report findings monthly to the QAPI committee. **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:** Audits will be completed 1x weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed by the QAPI committee for review and recommendations. **By what date the systemic changes will be completed:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			6/25/2021	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observation on 06/03/21 at 2:25 p.m. with the Administrator and Maintenance Director	K 0324	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(MD), the Kitchen was provided with an UL 300 hood system above the gas stove. Based on interview, the Dietary manager was asked "what is the first and second thing to do if there was a grease fire on the gas stove underneath the UL 300 hood system". The Dietary manager did not know about first pulling the ring to activate the UL 300 hood system to extinguish the fire and subsequently the "K" class fire extinguisher if the UL 300 system did not put out the fire. She further stated, "I thought the hood system went off by itself." This finding was reviewed with the Administrator during the exit conference 3.1-19(b)		*federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents in the vicinity of the kitchen have the potential to be affected by this alleged deficient practice. Dietary staff have been educated on the proper activation of the kitchen suppression system and use of the K extinguisher as a backup to the suppression system. Surveyor was incorrect on type of system. Suppression system automatically activates in event of a fire, staff did answer the question correctly. Manual pull is designed for a backup if the suppression fails to automatically engage. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff have been educated on the fire suppression system use and instructions for activating the system in event of a grease fire in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the cooking area. New dietary personnel will be instructed on the suppression system, location of activator button, location of K extinguisher and use of extinguisher during their job specific orientations. Dietary staff will review these procedures 1x per quarter during 1 of the quarter's fire drills or as deemed necessary. **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:** Any findings of dietary staff unable to explain or demonstrate the proper activation of the suppression system will immediately be retrained and documentation of training will be placed in employee files. Any non-compliance will be reported to the QAPI committee for review and recommendation. **By what date the systemic changes will be completed:** 6/25/2021	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure an automatic sprinkler system provided complete coverage in 3 of 3 areas observed. This deficient practice could affect only staff. Findings include: Based on observations on 06/03/21 during the tour between at 2:01 p.m. to 2:55 p.m. with the Administrator and Maintenance Director (MD), the following areas were not provided with sprinkler protection. a. The snow blower storage room. b. The elevator machine room. c. The enclosed area behind two gas dryers. Based on interview concurrent with the observations, the Administrator acknowledged items a and c were not provided with sprinkler protection and was unaware of the need for a sprinkler head in the elevator machine room. This was discussed with the Administrator during the exit conference. 3.1-19(b)	K 0351	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be**	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads was not obstructed in 1 of 1 Supply rooms in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 3 residents, visitors, and staff. Findings include: Based on observation on 06/03/21 at 4:02 p.m. with the Administrator and Maintenance Director (MD), in the Activities room on 700 hall there were assorted decorative items stored within 1/2 inch from the sprinkler head. Based on interview at the time of observation, the Administrator acknowledged the obstructions were less than eighteen inches from the sprinkler head. This was discussed with the Administrator during the exit conference. 3.1-19(b)		**identified and what corrective actions(s) will be taken:** **1.** · a. Outside storage area. Area does not open into the facility. Area is constructed of concrete walls, concrete floor and concrete ceiling/roof. Door is a metal door. Snow blower has been relocated for storage. As area no longer contains combustibles, does not open into any populated area and is fully constructed of non-combustible materials. · b. The elevator machine room has a sprinkler in place. Surveyor did not note this on rounding portion of survey. · c. The top of the enclosed area behind the dryers has been removed for access from the sprinklers already installed in the laundry area. 2. · Items were removed from sprinkled closet to ensure nothing is stored within 18” from the bottom of the sprinkler. Activity staff were educated on the importance of keeping any obstructions/stored items cleared in an area 18” from the bottom of sprinkler heads located in that area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** No	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			other areas of non-compliance were noted after survey rounds. Areas noted have not been modified or changed since opening construction and initial Life Safety inspection prior to opening facility. Corrections have been made to meet current survey requirements that are not grandfathered into the facility at opening. **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:** Results of the Life Safety Survey have been reviewed by the QAPI committee. Maintenance Director/ Designee continues to schedule sprinkler inspections as required. Any findings of non-compliance will be reported to the QAPI committee for recommendation. **By what date the systemic changes will be completed:** 6/25/2021	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 55 of 55 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 06/03/21 at 12:59 p.m. with the Maintenance Director (MD), the facility provided Fire Watch Policy and Procedure documentation, but it was incomplete. The Fire Watch Policy and Procedure plan only contacted ISDH and local fire authorities once the Sprinkler system has returned to normal service. This was confirmed and reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0354	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified as being affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The Fire Watch Policy has been revised to include all the entities be notified after fire	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			systems are restored that are notified when the system is out of order as per regulation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The revised Fire Watch Policy will be presented to the QAPI committee for review and approval. Management staff will be educated on the changes made to the Fire Watch Policy. **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:** Fire Watch Policy and Procedure will be reviewed by the QAPI committee and updated policy will be included in the Emergency Procedure Binders and reviewed annually. **By what date the systemic changes will be completed:** 6/25/2021	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview the facility failed to ensure 1 of 1 fire extinguishers observed was maintained with the gauge indicator reading	K 0355	*This plan of Correction is the facility's credible allegation of compliance.*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the operable zone. NFPA 10, 2010 Edition states at 7.2 2 (3) pressure gauge reading or indicator in the operable range or position. This deficient practice could affect 10 residents and staff. Findings include: Based on observation on 06/03/21 at 3:37 p.m. with the Administrator and Maintenance Director (MD), the ABC portable fire extinguisher labeled (#6) next to the Nursing station was showing the red indicator as discharged. Based on interview at the time of observation, the MD acknowledged the fire extinguisher was discharged and would have to be replaced. This was discussed with the Administrator during the exit conference. 3.1-19(b)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents and staff located in the area of this fire extinguisher have the potential of being affected by this alleged deficient practice. The fire extinguisher located near the 300-400 nurses' station has been replaced. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Fire extinguishers continue to be inspected monthly for proper condition. This extinguisher had	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			not been discharged, but gauge pressure was no longer in the green area. Any notations of extinguishers not passing inspection will be reported to the QAPI committee and extinguisher will be replaced. **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:** QAPI committee was reviewed the results of Life Safety Survey and correction of citation. QAPI committee will review any findings of non-compliance of fire extinguishers and note any recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation and interview, the facility failed to ensure 8 of 8 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 12 residents, visitors and staff. Findings include: Based on observations on 06/03/21 during the tour between 2:04 p.m. to 4:30 p.m. with the Administrator and Maintenance Director (MD), the following areas had penetrations in smoke barriers which were not sealed or improperly sealed with foam: a. Yellow foam used to seal around four conduits penetrating block walls in Laundry located in the basement. b. Basement corridor next to Electric room had numerous conduits penetrating block wall and orange foam was used to seal around penetrations. c. Electric room in basement there were numerous conduits penetrating the block wall and yellow foam was used to seal around penetrations. d. At least thirteen areas in the Basement storage area had conduits of various diameters penetrating the block walls and yellow and orange foam was used to seal around penetrations. e. Storage room, across from room #507 used foam to seal around HVAC ductwork. f. Smokewall next to Therapy used foam to seal around HVAC ductwork on East side of wall. g. Smokewall on 400 hall next to Nursing station, had a large pipe penetrating wall and the gap was	K 0372	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. a. Areas noted that do not have a fire rated "Fire Foam" or "Fire Caulk" have been scheduled to have the foam removed and replaced with "Fire Caulk". A temporary waiver request has been submitted to allow up to 90 days to correct. **What measures will be put into place or what systemic**	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not sealed. h. Service corridor smokewall used orange foam to seal around a one inch diameter conduit at the top of the wall and to the right there was TMC wires penetrating the wall and a bright yellow foam was used to seal the opening. Based on interview concurrent with each observation with the Administrator and MD, items a through h were all confirmed. This was discussed with the Administrator during the exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur:** Smoke barrier walls have been inspected and any penetrations not noted as being filled with fire rated caulk/foam have been filled with fire caulk. Maintenance Director/designee will inspect any contractor work that involves penetrating any smoke barriers for proper sealing of new penetrations. Results of repairs/corrections of smoke barrier penetrations will be reported to the QAPI committee. **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:** Any new construction, repairs, and/or maintenance that involves penetration of a smoke wall will be inspected and corrected if required for compliance. The QAPI committee will review reports for any further recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacles observed was protected accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect only staff. Findings include: Based on observation on 06/03/21 at 3:07 p.m. with the Administrator and Maintenance Director (MD), one electrical wall outlet in the Maintenance office was missing a plate cover. Based on interview at the time of observation, the MD confirmed the receptacle cover plate was missing and said it would be an easy fix. This was discussed with the Administrator during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 areas observed, protected electrical wiring according to NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect only staff. Findings include: Based on observation on 06/03/21 at 3:16 p.m. with the Administrator and Maintenance Director (MD), there were exposed electrical wires jutting out of a metal conduit next to the staff desk on vacant 200 hall. Based on interview at the time of	K 0511	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Staff and residents in the areas noted have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Outlet cover was replaced in the Maintenance Office.	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation, the MD acknowledged the exposed wires were not confined in an electrical junction box with a cover plate. This finding was discussed with the Administrator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 9 corridors with electrical circuit panels were secured from non-authorized personnel per LSC 19.5.1.1. LSC 19.5.1.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.2 states electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70 Section 110.27(A) states live parts of electrical equipment over 50 volts or more shall be guarded against accidental contact by approved closures or by any of the following means: (1) by location in a room, vault, or similar enclosure that is accessible only to qualified persons. This deficient practice could affect any residents, visitors and staff exiting 100 vacant hall. Findings include: Based on observation on 06/03/21 at 2:40 p.m. with the Administrator and Maintenance Director (MD) there were two electrical circuit panels installed in the corridor wall on 100 vacant hall which were not secured against non-authorized personnel. Based on interview during the observation, the MD confirmed the electrical panels were unsecured and could be opened by anyone and thought since they were on a vacant hall it would not matter. This was discussed with the Administrator during the exit conference. 3.1-19(b)		· Wiring on closed unit was completed as maintenance was in process of installing new lighting in this area. Wiring was not live and posed no exposure to injury. · Electrical panels on the nonpopulated area of facility have been secured. Staff were educated on the importance of identifying any areas that may be noted as not having outlet covers installed and in good condition or signs of any electrical wiring that is exposed in populated areas of the facility. Team is advised to report any findings of noncompliance to the Maintenance Director or Administrator for timely correction/repair. Any findings of noncompliance will be reported to the QAPI committee for review. **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:** Survey findings were reviewed by the QAPI committee. Any findings of noncompliance will be presented to the QAPI committee for review and recommendations for continued compliance. **By what date the systemic changes will be completed:** 6/25/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and observation, the facility failed to ensure at least 4 of 4 smoke/fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90 A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90 A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all occupants. Findings include:	K 0521	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Fire damper inspection was scheduled but delayed due to Covid-19. Inspection has been	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review on 06/03/21 at 1:15 p.m. with the Maintenance Director (MD), under the Fire Damper section of the Fire Safety logbook there was a single sheet of writing paper with the words "Done 09/20/20", no other information was given as to the location, condition, or inspection. Based on interview concurrent with record review, the MD stated that was the doing of the previous Maintenance Director. This was discussed with the Administrator during the exit conference. 3.1-19(b)		rescheduled. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: Maintenance Director/assistant were educated on the importance of including vendor documentation in the Life Safety binder for future reference. Vendor has been contacted and is scheduling an inspection date. Documentation of inspection will be entered into the Life Safety Binder for future reference. Copy of inspection will be presented to the QAPI committee for review. **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:** QAPI committee has reviewed citation, correction of citation and education process to ensure against further non-compliance. No further recommendations were provided. **By what date the systemic changes will be completed:** 6/25/2021	
K 0531 SS=F Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3			
	Based on observation, record review and interview, the facility failed to maintain testing of 1 of 1 elevators firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, visitors, and staff. Findings include: Based on observation on 06/03/21 at 1:45 p.m. with the Administrator and Maintenance Director (MD), the elevator had a key access fire department recall feature. Based on record review with the MD there was no documentation of a monthly firefighter recall test for the past year. Based on interview with the MD, when asked	K 0531	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation.	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	during record review it was indicated there was no documentation for the monthly firefighter recall testing for the elevator in the facility. This was discussed with the Administrator during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken**: This deficient practice could affect staff, elevator is for service staff only. Maintenance Director/ designee have been educated on the procedure and proper forms supplied by the vendor for documentation of monthly firefighter recall testing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Monthly testing will be completed, and documentation will be logged with copies in the Life Safety binder and a copy available in the elevator mechanical room. **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:** Copies of monthly testing will be presented to the QAPI committee by the Maintenance Director for 2 months. The plan will be adapted or adjusted as need to maintain compliance. **By what date the systemic changes will be completed:** 6/25/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview, the facility failed to ensure extinguished cigarette butts were properly disposed of in 1 of 1 outdoor areas where evidence of smoking occurred. This deficient practice could affect mainly staff who use the outside smoking location.	K 0741	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on review of the facility's written smoking policy on 06/03/21 at 12:22 p.m. with the Maintenance Director (MD), staff smoking is permitted on the premises outside the Closed unit. Based on observation with the Administrator and MD on 06/03/21 at 2:39 p.m., the smoking area for staff outside the Closed unit deposited cigarette butts in two large plastic containers with paper goods. Furthermore, at least 23 cigarette butts were observed on the pavement. Based on interview concurrent with the observation the Administrator was disappointed cigarette butts had been disposed of improperly. This was discussed with the Administrator during the exit conference. 3.1-19(b)		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken**: Staff could be affected by this alleged deficient practice. An extra smoke pot was ordered for the staff smoking area. Trash cans were removed from the smoking area and a metal fire can was installed for butt disposal. Staff that smoke have been educated on the proper maintenance of the assigned smoking area. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff smoking area is designated to one area on property. Smoke pots and a metal fire can have been installed in the immediate area for cigarette butt disposal. Trash cans are relocated to adjacent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			areas. Smoking area will be patrolled a minimum of 3x per week for 8 weeks to ensure compliance. **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:** Maintenance Director/designee will present to the QAPI committee results of the audits for 2 months for substantial compliance. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic changes will be completed:** 6/25/2021	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other	K 0761	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label.		**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents and staff in the facility have the potential to be affected by this alleged deficient practice. The Maintenance Director has added the fire rating tag inspection to the annual door inspection log. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A current inspection of fire doors was completed, and the documentation of inspection was placed in Life Safety binder for reference. Results of this inspection will be presented to the QAPI committee for review/recommendation of inspection. **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:** The QAPI committee will review the citation and the revised inspection documentation for compliance. The next annual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include: Based on record review on 06/03/21 at 12:30 p.m. with the Maintenance Director (MD), the last annual fire door assembly inspection available for review was simply written on one sheet of writing paper and stated "done 09/20/20". Based on interview at the time of record review, the MD stated the last fire door annual inspection was conducted by the last Maintenance Director. This finding was discussed with the Administrator during the exit conference.		inspection will be placed on the QAPI agenda for review for the May 2022 QAPI committee report. **By what date the systemic changes will be completed:** 6/25/2021	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of generator Weekly Test Log on 06/03/21 at 12:05 p.m., with the Maintenance Director (MD) the last weekly inspection of the generator was 04/05/21. Based on interview at the time of record review, the Administrator acknowledged the weekly inspections on the generator were inconsistent. This was discussed with the Administrator during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance	K 0918	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be**	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of generator Monthly Load Test Log on 06/03/21 at 12:05 p.m., with the Maintenance Director (MD) the last monthly load test done for the generator was 04/07/2021. Based on interview at the time of record review, the MD acknowledged the monthly load tests on the generator had not been done for May of 2021. This was discussed with the Administrator during the exit conference. 3.1-19(b)		**identified and what corrective actions(s) will be taken:** Residents, staff and visitors have the potential to be affected by the alleged deficient practice. Maintenance Director and Assistant Maintenance Director have been educated on the steps to complete a weekly inspection of the generator and document findings on the Generator weekly inspection log. Also instructed on process of completing monthly load tests and documenting the results on the Generator Monthly Load Test log. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Results of weekly and monthly reports will be reviewed monthly by the Administrator/designee for timeliness and compliance. Administrator signature of approval must be a part of documentation. Any findings of noncompliance will be addressed with correction and re-education if necessary and presented to the QAPI committee for review and recommendation. **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:** Weekly inspection and monthly load tests will be reviewed monthly and signed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the Administrator/designee. Any findings of non-compliance will be presented to the QAPI committee for review and recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure proper use of power strips and multi plugs in of 1 areas observed. This deficient practice could affect up to 2 residents, visitors	K 0920	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of*	06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and staff. Findings include: Based on observations on 06/03/21 during the tour between 12:09 p.m. to 3:46 p.m. with the Administrator and Maintenance Director (MD), a power strip or multi plug were improperly used in the following areas: a. A multi plug was used in the Dining room to power a juice machine and coffee maker when the outlet available was capable of powering the two appliances without a multi plug. This was corrected at the time of observation. b. A six prong multi plug was used the Medical records room to power a mini refrigerator and a power strip. Based on interview concurrent with the observations with the Administrator and MD, it was acknowledged the multi plug in item (a) was removed and the six prong multi plug was not hard wired and should not be used. This finding was discussed with the Administrator and MS during the exit conference. 3.1-19(b)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents, staff or visitors in the vicinity of the alleged deficient practices have the potential to be affected. Staff have been educated on the importance of reporting any type of electrical multi-plug observed in the facility immediately to their supervisor, Maintenance Director or Administrator. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The multiplugs were immediately removed. Inspections were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 01 B. WING	06/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			completed of remaining populated areas of facility with no other findings of non-compliance noted. Inspection of resident rooms multi plugs was added to the list of items to check on in the Guardian Angel program. Guardian Angels will check rooms a minimum of 1x weekly for any multi plug devices. Any findings of non-compliance must be corrected and reported to the Maintenance Director timely. This will remain a part of the Guardian Angel program. Education for resident/families may be required. **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:** The results of this citation were reviewed and discussed by the QAPI committee. Any findings of non-compliance will be reported to the QAPI Committee for review and recommendations. **By what date the systemic changes will be completed:** 6/25/2021	