PRINTED: 07/01/2021 FORM APPROVED

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	ì í	JILDING	ONSTRUCTION	(X3) DATE COMPI 06/03	LETED
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
E 0000 Bldg	conducted by the I accordance with 42 Survey Date: 06/0 Facility Number: Provider Number: AIM Number: 20 At this Emergency Health and Rehabic compliance with E Requirements for I	03/21 013420 155831	E 0	000			
E 0020 SS=F Bldg	the survey, the center of the survey, the center of Quality Review contents of the survey of the sur	1 certified beds. At the time of issus was 55. Impleted on 06/11/21 16.54(b)(2), 418.113(b)(6)(ii), 32.15(b)(3), 483.475(b)(3), 5.625(b)(3), 485.68(b)(1), 35.920(b)(2), 491.12(b)(1), and Primary/Alt. Comm. 3416.54(b)(2), §418.113(b)(6) 3), §460.84(b)(3), §482.15(b), §483.475(b)(3), §485.68(b) 3), §485.727(b)(1), 3491.12(b)(1), §494.62(b)(2) procedures. The [facilities]					

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

must develop and implement emergency preparedness policies and procedures, based

> TITLE (X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING		COMPL	
<u> </u>		155831	B. WING			06/03/	2021
NAME OF F	PROVIDER OR SUPPLIER	}			DDRESS, CITY, STATE, ZIP COD		
					ESTERN AVENUE		
BRIARCI	_IFF HEALTH & RE	HABILITATION CENTER	S	оитн	BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)		DATE
		/ plan set forth in paragraph risk assessment at					
	1 ' '	of this section, and the					
	communication plan at paragraph (c) of this						
	1	ies and procedures must be					
	reviewed and upd	ated at least every 2 years					
	l	facilities]. At a minimum,					
		rocedures must address					
	the following:]						
	[(3) or (1) (2) (6)	Safe evacuation from the					
	, , , , , , , , , , , , , , , , , ,	cludes consideration of care					
and treatment needs of evacuees; staff							
responsibilities; transportation; identification							
	of evacuation loca	ation(s); and primary and					
		of communication with					
	external sources of	of assistance.					
	*iFor RNHCIs at 8	§403.748(b)(3) and ASCs at					
	§416.54(b)(2):]	3					
	Safe evacuation fi	rom the [RNHCI or ASC]					
	which includes the						
		of care needs of evacuees.					
	(ii) Staff responsib						
	(iii) Transportation	n. of evacuation location(s).					
	(v) Primary and al	• •					
	1 ' '	ith external sources of					
	assistance.						
		3485.68(b)(1), Clinics,					
	_	encies, OPT/Speech at					
	\ \ \ \ \ \	nd ESRD Facilities at					
	§494.62(b)(2):]	rom the [CORF; Clinics,					
		encies, and Public Health					
	_	iders of Outpatient Physical					
	_	ech-Language Pathology					
		RD Facilities], which					
	includes staff resp	oonsibilities, and needs of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING		COMPL	ETED
		155831	B. WIN	IG		06/03/	/2021
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER			HBEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the patients.						
	* [For RHCs/FQHe evacuation from the includes appropriated staff responsibilities patients. Based on record responsibilities and procedures include evacuation from the consideration of case evacuees; staff responsidentification of evacuees; staff responsibilities and alternation with external source with 42 CFR 483.7 could affect all occurs affects all occurs and an evacuation. Base exit conference with stated the EPP would include the stated the EPP would include an evacuation.	Cs at §491.12(b)(1):] Safe the RHC/FQHC, which ate placement of exit signs; the sand needs of the view and interview, the facility the ergency preparedness policies and information for safe the LTC facility, which includes the and treatment needs of consibilities; transportation; accuation location(s); and the means of communication the es of assistance in accordance (3(b) (3). This deficient practice upants. The Emergency Preparedness to Administrator on 06/03/21 at as no documentation to indicate of evacuation locations during the high the Administrator it was all have to be updated to on of evacuation locations.	E 002	20	This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of a facts alleged or conclusions of 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 requespaper 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 a 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 bin were updated under Section Ethe Emergency Preparedness	of ot ment the et sts tion. II n the be re	06/25/2021

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	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BUILDING B. WING		COMPLETED 06/03/2021
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Manuals (EPM) for full building evacuation. Staff have been educated on the revision of th EMP. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Emergency Preparedness Bin have been updated to include evacuation locations. Binders remain on annual reviews and annual staff training on the EF will continue on-going. Review and training results will be presented to the QAPI commifor any revision. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Training and EMF binder education results will b presented to the QAPI commifornually for review and recommendations. By what date the systemic changes will be completed: 6/25/2021	e ders the swill low w ttee the the
E 0025 SS=F Bldg	482.15(b)(7), 483. 485.625(b)(7), 485 Arrangement with §403.748(b)(7), §4	.18.113(b)(5), §441.184(b) , §482.15(b)(7), §483.73(b)), §485.625(b)(7),			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	ľ	UILDING	NSTRUCTION	(X3) DATE COMPI 06/03	LETED
	PROVIDER OR SUPPLIEF	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	must develop and preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The polic be reviewed and tyears [annually for minimum, the polic address the follow *[For Hospices at §441.184,(b) Hos LTC Facilities at § procedures. (7) [or arrangements with other providers to of limitations or commination the continuitations or commination the continuitation of the section	implement emergency dicies and procedures, based of plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must appdated at least every 2 or LTC facilities]. At a cies and procedures must appdated at least every 2 or LTC facilities]. At a cies and procedures must applated at §482.15(b), and gi483.73(b):] Policies and or (5)] The development of an other [facilities] [and] receive patients in the event essation of operations to muity of services to facility 60.84(b), ICF/IIDs at less at §486.625(b), CMHCs de ESRD Facilities at ies and procedures. (7) [or lopment of arrangements are in the event of in the event of limitations or ations to maintain the coes to facility patients. 6403.748(b):] Policies and other over patients in the event of cation of operations to muity of non-medical					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2021	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to ensure ema and procedures incl arrangements with a providers to receive limitations or cessal the continuity of ser accordance with 42 deficient practice con Findings include: Based on review of Plan with the Admi at 11:45 a.m. on 06 arrangements with a providers to receive limitations or cessal available for review time of record review documentation of an	I patients. Friew and interview, the facility ergency preparedness policies ude the development of other LTC facilities and other cresidents in the event of cion of operations to maintain evices to LTC residents in CFR 483.73(b)(7). This ould affect all occupants. The Emergency Preparedness instrator during record review (03/21, documentation of other LTC facilities and other cresidents in the event of cion of operations was not to a Based on interview at the two, the Administrator agreed crangements with other callable for review at the time of	E 00	025	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 agreed 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 citat 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 to 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 affected by this alleged deficient practice. Mutual aide agreement have been sent to area facilities and facility will place them in the EPM when returned with signatures. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: LTC or this citation of the practice does not recur: LTC or this place in the practice does not recur: LTC or this place in the practice does not recur: LTC or this place in the practice does not recur: LTC or the provision of the pr	t ment the et sts ion. I he e e be ent eents es ine to	06/25/2021

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMF	E SURVEY PLETED 3/2021
	PROVIDER OR SUPPLIEF	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP C /ESTERN AVENUE I BEND, IN 46619	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				transfer agreements at the proper section of the Emergency Preparedner (EPM) (Appendix B). It management was educe EPM binder to include of Mutual Aide forms where LTC facilities. Binders on annual reviews and training on the EPM with one of more and training on the EPM with one of more and training on the EPM with one of th	ne less Manual Facility cated on the the location with other will remain I annual staff ill continue I training led to the hy revision. ction(s) ensure the not ty vill be put nd EMP ts will be committee d	
E 0039 SS=F Bldg	441.184(d)(2), 483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requit §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4 §485.625(d)(2), §4 (2), §491.12(d)(2)	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)				

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	UILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/03/2021	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	 5024 W	DDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	CMHCs at §485.9 §491.12, and ESF	ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]:				
	exercises to test t	acility] must conduct he emergency plan ility] must do all of the				
	community-based (A) When a community not accessible, co	nunity-based exercise is induct a facility-based				
	(B) If the [facinatural or man-material activation of the expression of the expressi	e every 2 years; or ility] experiences an actual ade emergency that requires mergency plan, the [facility]				
	community-based	gaging in its next required or individual, facility-based e following the onset of the				
	every 2 years, oppor functional exerc	ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) s conducted, that may				
	include, but is not (A) A second full-	limited to the following: scale exercise that is or individual, facility-based				
	(B) A mock disast (C) A tabletop exe led by a facilitator	er drill; or ercise or workshop that is and includes a group				
	set of problem sta	emergency scenario, and a tements, directed pared questions designed				
	(iii) Analyze the [fa maintain documer	nergency plan. acility's] response to and ntation of all drills, tabletop nergency events, and revise				

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	r OF HEALTH AND HU! R MEDICARE & MEDIC					RM APPROVED 1B NO. 0938-039	
STATEMEN	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 06/03	SURVEY LETED	
NAME OF F	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE			
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER	SOUTH	H BEND, IN 46619			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	OULD BE COMPLI		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	*[For Hospices at (2) Testing for ho the patient's home conduct exercises plan at least annu the following: (i) Participate in a community based (A) When a comm accessible, condu based functional e (B) If the hospice man-made emerg of the emergency exempt from enga scale community-l facility-based functional exercise of the emerg (ii) Conduct an ac years, opposite th functional exercise of this section is c include, but is not (A) A second full- community-based functional exercise (B) A mock disas (C) A tabletop ex- led by a facilitator discussion using a clinically-relevant set of problem sta	spices that provide care in a to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or aunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					

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(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice

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CENTERS FOI	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMP	LETED
		155831	B. W	'ING		06/03	/2021
	PROVIDER OR SUPPLIER	RHABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN OF CORRECTION	.T	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
IAG	per year. The hose (i) Participate in a that is community (A) When a commaccessible, condut facility-based functional exercise emergency exempt from engatull-scale community functional exercise emergency event. (ii) Conduct an activat may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extendilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and enter the hospice's emergency seems the hospice's emergency seems the hospice's emergency plan.	spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant ario, and a set of problem ted messages, or prepared ed to challenge an espice's response to and entation of all drills, tabletop ergency events and revise ergency plan, as needed.		IAG			DATE
	CAH1 must do the						

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(i) Participate in an annual full-scale exercise

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BUILDI B. WING	NG		COMPL 06/03/	
		100001				00/03/	ZUZ I
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
BDIVDO		HABILITATION CENTER			ESTERN AVENUE BEND, IN 46619		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER		JU 1 H	BEND, IN 400 19		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREF		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	that is community	R LSC IDENTIFYING INFORMATION	TA	u l	2-2-1-1-1-1		DATE
	-	nunity-based exercise is not					
	' '	ict an annual individual,					
		ctional exercise; or					
	(B) If the [PRTF, Hospital, CAH] experiences						
		or man-made emergency					
		ration of the emergency					
	·	is exempt from engaging in					
		ull-scale community based					
		ty-based functional exercise					
	following the onse	et of the emergency event.					
	(ii) Conduct a	an [additional] annual					
	exercise or and th	at may include, but is not					
	limited to the follo	wing:					
	(A) A second full-	scale exercise that is					
	community-based	or individual, a					
		ctional exercise; or					
		ock disaster drill; or					
	, ,	o exercise or workshop that					
		or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		he [facility's] response to umentation of all drills,					
		amentation of all drills, s, and emergency events					
	•	cility's] emergency plan, as					
	needed.	omy of officiacity biali, as					
	*[For PACE at §46	60.84(d):]					
		PACE organization must					
	· ,	s to test the emergency					
	plan at least annu	ally. The PACE					
	organization must	do the following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible condu	ict an annual individual	I				

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NXNK21 Facility ID: 013420

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	-	
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER		SOUTH	BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
	•	ctional exercise; or xperiences an actual natural					
	1 ' '	ergency that requires					
		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 a	an additional exercise every					
	2 years opposite the year the full-scale or						
	functional exercis	e 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						
	1	l or individual, a facility					
	based functional						
	(B) A mock disas						
	. , ,	ercise or workshop that is					
	discussion, using	and includes a group					
		emergency scenario, and a					
	1	atements, directed					
	1	pared questions designed					
	to challenge an e						
		PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emer	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):1					
	_	ity] must conduct exercises					
	_ , ,	ency plan at least twice per					
		nannounced staff drills using					
	1 -	ocedures. The [LTC facility,					
	ICF/IID] must do	the following:					
	(i) Participate in a	an annual full-scale exercise	1				
	that is community						
	` '	nunity-based exercise is not					
		ıct an annual individual,					
	facility-based fund	ctional exercise.					

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Event ID:

NXNK21 Facility ID: 013420

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	r í	UILDING	NSTRUCTION	(X3) DATE COMPI 06/03	LETED
	PROVIDER OR SUPPLIEF	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	actual natural or na requires activation LTC facility is exe required a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional (B) A mock disass (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an er (iii) Analyze the [I response to and nall drills, tabletop events, and revise emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in all that is community. (A) When a community (A) When a community cacessible, conductive facility-based function (B) If the ICF/IID exercises to manual or man-material or	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. [483.475(d)]: DF/IID must conduct the emergency plan at least e ICF/IID must do the					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155831	B. W	ING		06/03/	2021
NAME OF F	PROVIDER OR SUPPLIEF	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
					ESTERN AVENUE		
BRIARCI	LIFF MEALIH & KE	HABILITATION CENTER	•	SOUTH	I BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		gaging in its next required		IAG	DZI Telzive i		DATE
	•	nity-based or individual,					
		ctional exercise following the					
	onset of the emer						
		ditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	(A) A second full-						
	community-based						
	facility-based fund						
	(B) A mock disast						
	(C) A tabletop exercise or workshop that is led by a facilitator and includes a group						
	discussion, using						
	_	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[Ear ULIA = a+ 040	24 4001					
	*[For HHAs at §48	e HHA must conduct					
	, , , ,	he emergency plan at					
		e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	-	ommunity-based exercise					
		conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
	I facility based fund	tional exercise following the	1				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	r í	UILDING	NSTRUCTION	(X3) DATE COMPI 06/03	LETED
	PROVIDER OR SUPPLIE	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	years, opposite the functional exercise of this section is of include, but is not (A) A second community-based facility-based func (B) A mock d (C) A tabletor is led by a facilitar discussion, using clinically-relevant set of problem star messages, or pre to challenge an el (iii) Analyze the H maintain document exercises, and enthe HHA's emerged *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing e of the emergency	ditional exercise every 2 le year the full-scale or le under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is lor an individual, ctional exercise; or lisaster drill; or lo exercise or workshop that for and includes a group la narrated, lemergency scenario, and a litements, directed lipared questions designed limergency plan. HA's response to and lintation of all drills, tabletop linergency events, and revise lency plan, as needed. 86.360] le OPO must conduct lihe emergency plan. The lifollowing: ler-based, tabletop exercise last annually. A tabletop la facilitator and includes a lusing a narrated, clinically locy scenario, and a set of lifts, directed messages, or lift the OPO experiences an lift the OPO experiences an lift the OPO experiences an lift the opological in the lower engaging in its next lift were recise following the onset					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/03/2021
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the conduct a paperat least annually. It is group discussion in arrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emel Based on record reversided to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community-based function in the emergency plan from engaging its not community-based of the emergency plan engaging its not community-based of the emer	e RNHCI must conduct the emergency plan. The the following: the following and the following and following and the following are following are following and the following are followed and the following ar	E 0039	This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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 reques paper compliance for this cital what Corrective action(s) will be accomplished for those residents found to have bee affected by the deficient	of ot ment the eet ests tion.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED
		155831	B. WI	NG		06/03/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ESTERN AVENUE	
BRIARCI	I IEE HEAI TH & RE	HABILITATION CENTER			H BEND, IN 46619	
DIVIAIVO	·	HABIETATION CENTER		00011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	a. A second full-sca				practice: No residents were	
		or an individual, facility-based			identified in this citation.	
	functional exercise.				How other residents having	
	b. A mock disaster				potential to be affected by the	
	_	ise or workshop that is led by a			same deficient practice will be	
		ides a group discussion, using			identified and what correctiv	е
		y-relevant emergency scenario,			actions(s) will be taken: All	
	_	n statements, directed			residents have the potential to	
		red questions designed to			affected by this alleged deficie	
	challenge an emergency plan.				practice. Facility has complet	ed a
	(iii) Analyze the LTC facility's response to and				tabletop exercise and will	
		naintain documentation of all drills, tabletop			complete another exercise/dri	
	exercises, and emergency events, and revise the				that will activate the use of the	
	LTC facility's emergency plan, as needed in				Emergency Preparedness Ma	
		CFR 483.73(d)(2). This			within the year. Documentation	on of
	deficient practice co	ould affect all occupants.			the facility disaster	
	F: 1: 1 1				exercise/training was placed in	
	Findings include:				Emergency Preparedness bin	der
	D 1 . (N. D. 1			for future reference.	
		Emergency Preparedness			What measures will be put in	ito
		/03/21 at 11:55 a.m. with the			place or what systemic	
		facility lacked documentation			changes will be made to	
		nunity based exercise over the			ensure that the deficient	
		the facility documented an natural or man-made			practice does not recur:	
	_	uired activation of the			Maintenance Director/Designe	
		hich would exempt the facility			will schedule 1 annual tableto	•
		ext required full-scale in a			exercise or community-based exercise plan in coordination v	
		or individual, facility-based			District 2 Healthcare Coalition	
	-	l exercise for 1 year following			1 disaster drill that will require	
		ual event. Based on interview			activating use of the Emergen	
		ference the Administrator			Preparedness Manual each ye	
		ommunity based exercise had			going forward. QAPI commit	
		he past year nor any other			and facility management team	
		es which would involve the			be advised of scheduled exerc	
	implementation of				and review completed	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		 • •			documentation for	
					recommendations.	
					How the corrective action(s)	
					will be monitored to ensure t	
	i .		1		I So momento de chisule i	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 06/03/2021		
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE 1 BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000				deficient practice will not recur, i.e., what quality assurance program will be p into place: Completed documentation of any exercise will be reviewed by the QAPI committee for recommendatio Exercises/drills will be schedu with the QAPI committee/ager to ensure completion and review and the completed: 6/25/2021	ns. led nda
Bldg. 01	Licensure Survey v Department of Hea 483.90(a). Survey Date: 06/02 Facility Number: (Provider Number: 201 At this Life Safety and Rehabilitation compliance with Re Medicare/Medicaic Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup This one story facil Type II (000) const	013420 155831	K 0000		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155831	B. W	ING		06/03	/2021
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	R			ESTERN AVENUE		
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER			I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with smoke detection	on in the corridors, all areas					
	open to the corrido	r 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 th	is survey.					
	All areas where res	idents have customary access					
		nd all areas providing facility					
	services were sprin						
	Quality Review con	mpleted on 06/11/21					
K 0000	NEDA 404						
K 0222 SS=E	NFPA 101						
	Egress Doors						
Bldg. 01	Egress Doors	. d					
		ed means of egress shall not					
		a latch or a lock that					
		of a tool or key from the					
	_	s using one of the following					
	special locking ar	_					
		S OR SECURITY THREAT					
	LOCKING						
		cking arrangements for the					
	1	eeds of the patient are					
	1	cking device shall be					
	1 -	n door and provisions shall					
		apid removal of occupants					
	1 -	of locks; keying of all					
		ied by staff at all times; or					
		e means available to the					
	staff at all times.						
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
		cking arrangements for the					
		ne patient are used, all of					
	the Clinical or Sec	curity Locking requirements					

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are being met. In addition, the locks must be electrical locks that fail safely so as to

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Facility ID: 013420

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155831	B. W	ING		06/03/	/2021
NAME OF I	PROVIDER OR SUPPLIER	?	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					/ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH	H BEND, IN 46619		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		of power to the device; the					
		ed by a supervised					
		er system and the locked					
		d 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. 18.2.2.5.2, 19.2.2.2.5.2, TIA 12-4					
	l '						
	DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking						
	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door						
		ng low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2						
		ROLLED EGRESS					
	LOCKING ARRAI						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.	ianos mar r.z. r.o.z enan					
	18.2.2.2.4, 19.2.2	2.4					
		BY EXIT ACCESS					
	LOCKING ARRAI						
		it access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		ised automatic sprinkler					
	system.	·					
	18.2.2.2.4, 19.2.2	.2.4					
		on and interview, the facility	K 0	222	This plan of Correction is the		06/25/2021
	failed to provide ac	cess to means of egress for 1			facility's credible allegation of		
	of 1 Courtyard exit	discharge observed with a			compliance.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/03/2021 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE SOUTH BEND, IN 46619 BRIARCLIFF HEALTH & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE combination lock installed on the inside in Preparation and/or execution of accordance with the requirements of NFPA 101 this plan of correction does not 2000 edition, Sections 19.2, 19.2.2.2 and 19.2.2.2.4. constitute admission or agreement This deficient practice could affect any resident, by the provider of the truth of the staff or visitor in the Dining room. facts alleged or conclusions set forth in the statement of Findings include: deficiencies. The plan of correction is prepared and/or Based on observation on 06/03/21 at 2:11 p.m. executed solely because it is with the Administrator and Maintenance Director required by the provisions of (MD), the Courtyard gate outside the Dining room federal and state law. was equipped with a combination lock on the This facility respectfully requests inside. Based on interview at the time observation paper compliance for this citation. with the Administrator and MD, the QMA and the What Corrective action(s) will CNA were asked if they knew the combination of be accomplished for those the lock on the Courtyard gate and both staff said residents found to have been they did not know nor did anyone else. The affected by the deficient Administrator added, this lock had just been practice: No residents were installed and there hadn't been enough time to identified in this citation. inform staff of the combination. This was How other residents having the discussed with the Administrator during the exit potential to be affected by the conference. same deficient practice will be identified and what corrective 3.1-19(b) 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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/03/2021
	PROVIDER OR SUPPLIE	R EHABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				practice does not recur: Sta will be educated on the proce entering the codes to open the padlocks in event of an emergency. Continued educ will be provided in the event of need to change padlock code and reviewed in the annual Emergency Preparedness review. Maintenance Director/designee will intervie minimum of 5 staff weekly x 8 weeks to ensure staff know e the correct code or where to locate the code, this will incluagency and contracted staff. How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place: Maintenance Director/designee will present the QAPI committee results of audits for 2 months for substacompliance. Results of the a will be reviewed in QAPI and will be adapted or adjusted an needed to maintain compliant By what date the systemic changes will be completed: 6/25/2021	ess of the antial udits plan s
K 0225 SS=E Bldg. 01	Stairways and Sn Stairways and Sn as exits are in ac 18.2.2.3, 18.2.2.4	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used cordance with 7.2. 1, 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility	K 0225	This plan of Correction is the	06/25/2021

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPLE	ETED
		155831	B. WING			06/03/2	2021
		<u> </u>	S	TREET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			ESTERN AVENUE		
BRIARCI	IFF HFAI TH & RF	HABILITATION CENTER			BEND, IN 46619		
	1				22.13, 11 10010		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	_	continuous protected path of			facility's credible allegation of		
		charge for 1 of 1 stairwells in			compliance.		
		SC sections 7.2.3.5. LSC			Preparation and/or execution		
	_	very smoke proof enclosure			this plan of correction does no		
		a public way, into a yard or			constitute admission or agree		
		access to a public way, or into			by the provider of the truth of t		
		. Such exit passageways shall			facts alleged or conclusions se	et	
		be without openings other than the entrance from the smoke proof enclosure and the door to the			forth in the statement of		
	the smoke proof enclosure and the door to the outside yard, court, or public way. The exit				deficiencies. The plan of		
	-				correction is prepared and/or		
		passageway shall be separated from the remainder of the building by a two hour fire resistance			executed solely because it is required by the provisions of		
					federal and state law.		
	rating. This deficient practice affects all residents, staff and visitors.				This facility respectfully reques	ete	
	starr and visitors.				paper compliance for this citat	I	
	Findings include:				What Corrective action(s) will		
	i manigs metade.				be accomplished for those	"	
	Based on observation	on on 06/03/21 at 2:46 p.m.			residents found to have beer	,	
		ator and Maintenance Director			affected by the deficient	'	
		t stairwell door had a fire			practice: No residents were		
		pel, but it was painted over and			identified in this citation.		
	_	ating could not be determined.			How other residents having t	the	
		at the time of the observation,			potential to be affected by th		
		ged the fire resistance rated			same deficient practice will be		
		ver and he could not ascertain			identified and what correctiv		
	its fire rating. This	was discussed with the			actions(s) will be taken: This	I	
		ng the exit conference.			alleged deficient practice could		
					affect any staff/ resident locate		
	3.1-19(b)				the area of stairwell. The fire		
					rating tag was cleared of any	paint	
					and can be viewed for rating.		
					What measures will be put in	ito	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Maintenance staff will be educ	ated	
					on the importance of not paint	ing	
					over any fire rating located on		
					smoke and fire doors. When		

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2021	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				painting/repairing any doors in future, notation of any tags no clearly visible should be report to the supervisor/administrator timely. Inspection of fire/smodoors throughout the populate 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 printo place: Fire rating tage inspections will be added to the annual door inspection report. Any findings of non-compliance will be corrected immediately. Results of this annual report where the presented to QAPI for any recommendations. By what date the systemic changes will be completed: 6/25/2021	t ted r ke d d che ut	
K 0232 SS=E Bldg. 01	unobstructed) ser at least 4 feet and convenient remov on stretchers, exc 19.2.3.4, exception 19.2.3.4, 19.2.3.5 1. Based on observen	Ramp Width s or corridors (clear or ving as exit access shall be a maintained to provide the val of nonambulatory patients bept as modified by ons 1-5.	K 0232	This plan of Correction is the	06/25/2021	
		exit access routes free and clear 1 of 9 corridor exit access in		facility's credible allegation of compliance.		

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Event ID:

 $NXNK21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 013420$

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155831	B. WI	NG		06/03/2021	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ESTERN AVENUE		
BRIARCL	JIFF HEALTH & RE	HABILITATION CENTER			I BEND, IN 46619		
_					, -		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	т
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	1
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
		e requirements of NFPA 101,			Preparation and/or execution		
		ns 19.2, 19.2.1, 7.1.10 and			this plan of correction does no		
		eient practice could affect any			constitute admission or agree		
		sitor exiting through the 100			by the provider of the truth of the		
	Vacant hall.				facts alleged or conclusions so	eτ	
	Tindiana indeple				forth in the statement of		
	Findings include:				deficiencies. The plan of		
	D 1 1 2	Based on observation on 06/03/21 at 2:35 p.m.			correction is prepared and/or		
	Based on observation on 06/03/21 at 2:35 p.m. with the Administrator and Maintenance Director				executed solely because it is		
					required by the provisions of		
	(MD) there was two resident beds, crates, and				federal and state law.	,	
	pallets full of boxes stored in the corridor of 100				This facility respectfully reque		
	Vacant hall reducing the eight foot width of the				paper compliance for this citat		
		s. Based on interview			What Corrective action(s) wi	II	
	concurrent with the				be accomplished for those		
		d the 100 hall was vacant and			residents found to have been	ו	
	_	be surveyed. This was			affected by the deficient		
		ninistrator during the exit			practice: The corridor to the		
	conference.				unpopulated area located in th		
					closed 100-200 unit was clear		
	3.1-19(b)				any obstructions. The resider		
					chairs located near the nurse's	S	
		ation, the facility failed to meet			station on the 700 unit were		
	-	pirement for 1 of 9 corridors or			removed from the corridor.		
		er 19.2.3.4(5). LSC 19.2.3.4(5)			How other residents having		
		ridor width is at least 8 feet,			potential to be affected by th		
		required width shall be			same deficient practice will be		
	-	furniture, provided that all of			identified and what correctiv		
	the following condi				actions(s) will be taken: Any		
		re is securely attached to the			residents/ staff could be affect		
	floor or to the wall.				by this alleged deficient practi		
	* /	re does not reduce the clear			The corridor to the unpopulate		
		or width to less than six feet,			area located in the closed 100	-200	
	except as permitted				unit was cleared of any		
		re is located only on one side			obstructions. The resident cha		
	of the corridor.	1 1 2			located near the nurse's static		
		are is grouped such that each			the 700 unit were removed fro		
		exceed an area of 50 square			the corridor. Staff have beer		
	feet.				educated on the importance o	f	
	(e) the fixed furnitu	re groupings addressed in			ensuring all exit corridors are		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155831	B. W	ING		06/03/2021	
				STREET	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF P	ROVIDER OR SUPPLIER				/ESTERN AVENUE		
BRIARCI	IFF HEAI TH & RE	HABILITATION CENTER			H BEND, IN 46619		
DI (I) (I (OL	- III IILALIII WAL	TINDIETT/TTOIN GENTER		00011	1 BEND, IIV 40010		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	t
TAG		LSC IDENTIFYING INFORMATION	_	TAG		DATE	
		eparated from each other by a			always clear of obstacles.		
	distance of at least				What measures will be put in	to	
	` '	re is located so as to not			place or what systemic		
		uilding service and fire			changes will be made to		
	protection equipmen				ensure that the deficient		
		hout the smoke compartment			practice does not recur: State	f	
		electrically supervised			have been educated on the		
		stection system in accordance			importance of ensuring all exit		
		ixed furniture spaces are			corridors are always clear of		
		d to allow direct supervision			obstacles. Maintenance		
		from a nurse's station or similar			Director/designee will do		
	space.				observations a minimum of 5		
		artment is protected			times weekly x 8 weeks to		
		proved, supervised automatic			ensure exit corridors are clear of		
		accordance with 19.3.5.8			any obstacles. Summary of these		
	_	ice could affect any resident,			observations will be presented	to	
	visitor or staff using	g the 700 hall exit.			the QAPI committee.		
					How the corrective action(s)		
	Findings include:				will be monitored to ensure t	he	
		0.5/0.2/0.1			deficient practice will not		
		on on 06/03/21 at 4:00 p.m.			recur, i.e., what quality		
		tor and Maintenance Director			assurance program will be p	ut	
	, ,	lirectly across from the Nursing			into place: Maintenance		
		airs unsecured in the corridor			Director/designee will present		
	_	tht feet wide limiting the			the QAPI committee results of		
		ss than five feet. Based on			audits for 2 months for substan		
		e of the observation and			compliance. Results of the au		
		he Administrator and MD it			will be reviewed in QAPI and p	olan	
	_	the chairs were not secured			will be adapted or adjusted as		
		d the chairs. This finding was			needed to maintain complianc	e.	
		Administrator at the exit			By what date the systemic		
	conference.				changes will be completed:		
	2 1 10(b)				6/25/2021		
	3.1-19(b)						
K 0291	NFPA 101						
SS=C	Emergency Lightir	ng.					
Bldg. 01	Emergency Lightin	_					
Diag. 01		g of at least 1-1/2-hour					
	duration is provide	-					
	duration is provide	o automatically III	ı		1	1	

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07/01/2021 PRINTED:

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	` ′	JILDING	onstruction 01	(X3) DATE COMPI 06/03	SURVEY LETED
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE		VESTERN AVENUE		
BRIARC	LIFF HEALTH & RE	EHABILITATION CENTER		SOUTI	H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	accordance with 18.2.9.1, 19.2.9.1 Based on observatifailed to ensure 4 of tested monthly for minutes over the pay would provide light outages and a writt and tests was provide mergency lighting accordance with Soft requires functional monthly, with a min maximum of 5 west than 30 seconds, (3 conducted annually if the emergency liphowered and (5) Winspections and test for inspection by the jurisdiction. This of residents in the fact Findings include: Based on record rewith the Maintenar Backup Light Test specify the time the the monthly or annually past year. Based on record review, the documentation of the Test log. This was	on and interview, the facility of 4 battery backup lights were 30 seconds and annually for 90 ast year to ensure the light ting during periods of power en record of visual inspections ded. LSC 19.2.9.1 requires g shall be provided in ection 7.9. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a eks between tests, for not less by Functional testing shall be of for a minimum of 1 1/2 hours ghting system is battery fritten records of visual ts shall be kept by the owner he authority having deficient practice could affect all ility. View on 06/03/21 at 12:20 p.m. nee Director (MD), the Battery Log for 2020 to 2021 did not be lights were tested for either ual tests conducted over the nan interview at the time of MD indicated the lack of ime in the Battery Backup Light	K 0		This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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 reques paper compliance for this cital what Corrective action(s) where the deficient practice: The battery backup light test log has been modified show the time of the test. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions(s) will be taken: All residents have the potential that 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 in place or what systemic	f of ot ement it the set sets setton. iill en o ed to the he be ve o be ent is	06/25/2021

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place or what systemic changes will be made to ensure that the deficient

practice does not recur: Testing

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/03/2021
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				of emergency lighting battery backup will continue as sched for compliance. The log has be revised so time of test can be included on the report. Maintenance staff have been educated on the revised log at completion of log. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be previewed 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	nd the
K 0293 SS=E Bldg. 01	accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of 6 1. Based on record	al signs are displayed in 7.10 with continuous erved by the emergency ne-story existing less than 30 occupants exit travel is obvious.) review and interview; the tall exit signage in 1 of 9	K 0293	This plan of Correction is the facility's credible allegation of	06/25/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN				JILDING	01	COMPLETED	
		155831	B. Wl	ING		06/03/2021	
NAME OF P	DROWINED OF GUIDNI TER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIEF			5024 W	/ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH	H BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETI	ION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ance with LSC 7.10. LSC			compliance.		
	· · · · · · · · · · · · · · · · · · ·	er than main exterior exit doors			Preparation and/or execution		
	I	clearly are identifiable as exits,			this plan of correction does no	ot	
		an approved sign that is			constitute admission or agree		
		any direction of exit access.			by the provider of the truth of		
		es horizontal components of the			facts alleged or conclusions s	et	
		nn exit enclosure shall be			forth in the statement of		
		d exit or directional exit signs			deficiencies. The plan of		
		ion of the egress path is not			correction is prepared and/or		
		ient practice could affect 25			executed solely because it is		
	residents, visitors, a	and staff.			required by the provisions of		
					federal and state law.		
Findings include:					This facility respectfully reque	sts	
					paper compliance for this cital	tion.	
		on on 06/03/21 at 3:22 p.m.			What Corrective action(s) wi	II	
		ator and Maintenance Director			be accomplished for those		
	, ,	al exit smoke/fire doors on			residents found to have bee	า	
		ot provided with an exit sign on			affected by the deficient		
		smoke wall to indicate a			practice: No residents were		
		Based on interview at the time			identified in this citation.		
		MS acknowledged there were			How other residents having	the	
		signs on both sides of the			potential to be affected by the		
		ired. This finding was			same deficient practice will		
		Administrator during the exit			identified and what corrective		
	conference.				actions(s) will be taken: This		
					an un-occupied area of facility		
	3.1-19(b)				closed to residents. Staff who		
					in the un-occupied area have		
		ation and interview, the			potential to be affected by this		
	1	sure 1 of 9 corridor doors			alleged deficient practice. A		
	_	de of the facility were not			bi-directional lighted exit sign		
		ty exit. LSC 7.10.8.3.1 states			been ordered and will be insta	illed	
		or stairway that is neither an			to meet compliance.		
	I	tit access and that is located or			What measures will be put in	nto	
		s likely to be mistaken for an			place or what systemic		
		ied by a sign that reads as			changes will be made to		
		The NO EXIT sign shall have			ensure that the deficient		
		ers 2 inches high, with a stroke			practice does not recur: An		
		nd the word EXIT below the			inspection of exit corridors in		
	word NO, unless su	ch sign is an approved			populated areas of facility fou	nd no	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155831	B. W	ING		06/03/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			1	ESTERN AVENUE		
BRIARCL	IFF HEALTH & RE	HABILITATION CENTER			I BEND, IN 46619		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		deficient practice could affect			further areas of non-compliand	e of	
	20 residents, staff, a	and visitors.			exit signs.		
					How the corrective action(s)		
	Findings include:				will be monitored to ensure t	he	
	D 1 1 4	06/02/21 4.2.10			deficient practice will not		
		on on 06/03/21 at 3:10 p.m. tor and Maintenance Director			recur, i.e., what quality	.4	
		ne 100 vacant hall which leads			assurance program will be pu	ıτ	
	* **	facility does not have any			into place: The Maintenance Director/designee will report to	the	
		the interpreted as an exit			QAPI committee when proper	uic	
		e Administrator does not want			placement of exit light is		
		rough 100 hall. Based on			completed. As this one area	of	
	-	Administrator concurrent with			non-compliance will be correct		
	the observation it w	as acknowledged the 100			no further reporting to the QAF		
	vacant hall corridor	was not to be used as an exit			committee will be required.		
	event though it was	a legitimate exit and			By what date the systemic		
	_	oor was not provided with a			changes will be completed:		
	_	further stated this was a			6/25/2021		
	vacant hall and shou	ıld not be surveyed.					
	3.1-19(b)						
K 0321	NFPA 101						'
SS=E	Hazardous Areas						
Bldg. 01	Hazardous Areas						
		are protected by a fire					
	•	our fire resistance rating rated doors) or an					
	•	•					
		nguishing system in .7.1 or 19.3.5.9. When the					
		ic fire extinguishing system					
		areas shall be separated					
	•	by smoke resisting					
	•	rs in accordance with 8.4.					
	Doors shall be self	f-closing or					
		and permitted to have					
	nonrated or field-a	pplied protective plates that					
	do not exceed 48	inches from the bottom of					
	the door.						
	Describe the floor	and zone locations of					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155831	B. W	NG		06/03/	2021
				CEDECE	ADDRESS OF A STATE OF COD		
NAME OF I	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE		
DDIADCI		LIABILITATION CENTED					
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER		3001H	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	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 (larg	er than 100 square feet)					
	c. Repair, Mainter	nance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collection Rooms (exceeding 64 gallons)						
	f. Combustible Sto	orage Rooms/Spaces					
	(over 50 square fe	eet)					
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	•					
		ration and interview, the	K 0	321	This plan of Correction is the		06/25/2021
		sure 6 of 7 hazardous areas			facility's credible allegation of		
		torage rooms over 50 square			compliance.		
		their frame and be provided			Preparation and/or execution	of	
		device. This deficient practice			this plan of correction does no		
		its in the adjacent smoke			constitute admission or agreei		
	_	ll as staff on 100 vacant hall			by the provider of the truth of t		
	and Supply room.				facts alleged or conclusions se	et	
					forth in the statement of		
	Findings include:				deficiencies. The plan of		
	D 1 1 1	06/02/01 1 : 3			correction is prepared and/or		
		ons on 06/03/21 during the			executed solely because it is		
		p.m. to 3:35 p.m. with the			required by the provisions of		
		Maintenance Director (MD),			federal and state law.		
		were either not provided with			This facility respectfully reques		
		ere not equipped with a			paper compliance for this citat		
	self-closing device:				What Corrective action(s) will	II	
		in room #4 stored 16 cardboard			be accomplished for those		
		lor door was installed.			residents found to have beer	ו	
		in room #7 stored 25 cardboard			affected by the deficient		
		lor door was installed.			practice: No residents were		
		in room #12 stored "too many			identified in this citation.		
	to count" TMC care	dboard boxes and no corridor	1		How other residents having t	the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG 01	(X3) DATE S COMPLI 06/03/2	ETED	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	502	REET ADDRESS, CITY, STATE, ZIP COI 24 WESTERN AVENUE OUTH BEND, IN 46619	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREF	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	door was installed. d. Central supply of stored 47 cardboard corridor door was in e. Central supply of stored 39 cardboard equipped with a clot of. Supply room adjusted boxes and closure on the corridor based on interview with the Administration hall and 200 hall be subject to inspect abide by LSC regul further added the State of the self-closing device acknowledged the attribute at This was discussed MS during the exit self-closing device acknowledged the attribute at This was discussed MS during the exit self-closing device acknowledged the attribute at This was discussed my during the exit self-closing of could affect all residual feet and the poppers in a room with a self-closing of could affect all residual feet all r	n 200 vacant Service hall boxes in room #1 and no installed. In 200 vacant Service hall boxes in room #2 was not sure on the corridor door. acent to dining room stored 21 d was not equipped with a dor door. at the time of observations attor and MD it was stated the ll were vacant and should not tion and was not required to ations. The Administrator apply room would have a installed and also areas were over 50 square feet. with the Administrator and			by the will be rective : ected by ctice on facility. 0-800 unit affected ocorn ce. educated items in a closure the areas in automatic s. Stored istible on 0 unit will installed orridors pulated. Items is an ce as was eveyor ds of put into to tt: Other populated ected and	
	Based on interview	at the time of observation, the		· a-f- this area rema	ains I	

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	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BUILDING B. WING	01	COMPLETED 06/03/2021
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 W	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	taken to the Dining Dining room was or	I the popcorn machine was room when in use and the pen to the corridor. This ed with the Administrator erence.		locked and unpopulated. A dumpster has been ordered to dispose of items no longer in the for facility. Any items deemed combustible will be placed in rooms with a closure installed Noncombustible items will be stored in rooms, not in corridor Corridors will remain clear. 2. A closure device was installed on the activity office of 700-800 unit. Supervisors were educated or safety of storing any combustificems in rooms with doors equipped with closure devices Activity staff were educated or locations that the popcorn machine can be used safely. Maintenance Director/designed 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 find monthly to the QAPI committed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place: Audits will be completed 1x weekly for 4 we then monthly for 2 months. Results of the audits will be reviewed by the QAPI committed for review and recommendations. Results of the audits will be reviewed by the QAPI committed to the systemic changes will be completed:	use I as

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Event ID:

 $NXNK21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 013420$

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		r '	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING 01 CO. B. WING 06/			
	PROVIDER OR SUPPLIER	L HABILITATION CENTER	50	TREET ADDRESS, CITY, STATE, ZIP (D24 WESTERN AVENUE OUTH BEND, IN 46619	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IC PRE	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord; 19.3.2.5.2 * cooking facilities smoke compartment patients comply with 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under Cooking	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ing equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. Protected according to 3 are not required to be redous areas, but shall not rridor.	K 0324	This plan of Correction facility's credible alleg compliance. Preparation and/or ex this plan of correction constitute admission of by the provider of the facts alleged or conclusion to the facts alleged or conclusion to the facts alleged or conclusion to the facts alleged or conclusion in the statement deficiencies. The plan correction is prepared executed solely because required by the provise.	gation of secution of does not or agreement truth of the usions set of n of d and/or use it is	06/25/2021

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Event ID:

 $NXNK21 \quad \text{Facility ID:} \quad 013420 \qquad \qquad \text{If continuation sheet} \quad \text{Page 34 of 61}$

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/03/2021
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Was provided with an LH 200	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	hood system above interview, the Dieta the first and second grease fire on the g 300 hood system". know about first pu UL 300 hood system subsequently the "K UL 300 system did further stated, "I the off by itself." This	was provided with an UL 300 the gas stove. Based on ary manager was asked "what is thing to do if there was a as stove underneath the UL The Dietary manager did not alling the ring to activate the m to extinguish the fire and the cought the hood system went finding was reviewed with the mg the exit conference		federal and state law. This facility respectfully reque paper compliance for this citate. What Corrective action(s) wis be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by alleged deficient practice. How other residents having potential to be affected by the same deficient practice will lidentified 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 be educated on the proper activated of the kitchen suppression system. Surveyor was incorred on type of system. Suppression system automatically activated event of a fire, staff did answer question correctly. Manual put designed for a backup if the suppression fails to automatic engage. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Die staff have been educated on the irre suppression system use an instructions for activating the system in event of a grease file.	tion. II n this the ne
				System in event of a grease in	

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AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		X3) DATE SURVEY COMPLETED 06/03/2021		
	PROVIDER OR SUPPLIER LIFF HEALTH & RE	HABILITATION CENTER	5024 W	/ESTERN AVENUE I BEND, IN 46619	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LIGGIDENTIFYING DIFFERMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	the cooking area. New dietary personnel will be instructed or suppression system, location of activator button, location of K extinguisher and use of extinguisher during their job specific orientations. Dietary swill review these procedures 1 per quarter during 1 of the quarter's fire drills or as deem 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 printo place: Any findings of dietary staff unable to explain demonstrate the proper activation of the suppression system will immediately be retrained and documentation of training will placed in employee files. Any non-compliance will be reported the QAPI committee for review recommendation. By what date the systemic changes will be completed: 6/25/2021	a the of staff x ed the ut or tion be
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in	Installation nd hospitals where required			

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Systems.

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Facility ID: 013420

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155831	B. WI	ING		06/03	/2021
	PROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD /ESTERN AVENUE I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	protection measure substituted for sprareas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, 1 1. Based on observe facility failed to ensight failed to ensigh failed to ensigh failed to ensigh failed. This definition of the following areas sprinkler protection a. The snow blowe b. The elevator mac. The enclosed are Based on interview observations, the Aitems a and c were protection and was sprinkler head in the	r storage room.	K 0	351	This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of 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 requespaper compliance for this cital 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 a some deficient practice.	of nent the et sts tion. II n	06/25/2021

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Event ID:

NXNK21 Facility ID: 013420

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		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSIDENTIFICATION NUMBER A. BUILDING 155831 B. WING		nstruction <u>01</u>	(X3) DATE COMPL 06/03 /	ETED	
		ROVIDER OR SUPPLIEF	HABILITATION CENTER	50	24 W	DDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) PRE	FIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
PREI TA		2. Based on observe facility failed to ensist sprinkler heads was Supply rooms in act 13, 2010 edition, So shall be located so a discharge as defined additional sprinkler adequate coverage and 8.5.5.3 do not pronocontinuous obst 18 inches below the horizontal plane mosprinkler deflector to from fully developic could affect 3 reside. Findings include: Based on observation with the Administration (MD), in the Activities assorted decorative from the sprinkler lettime of observation acknowledged the ceighteen inches from	ation and interview, the sure the spray pattern for a not obstructed in 1 of 1 cordance with 19.3.5.1. NFPA ection 8.5.5.1 states sprinklers as to minimize obstructions to d in 8.5.5.2 and 8.5.5.3 or as shall be provided to ensure of the hazard. Sections 8.5.5.2 obermit continuous or ructions less than or equal to exprinkler deflector or in a sore than 18 inches below the exhat prevent the spray pattern ing. This deficient practice ents, visitors, and staff.	PREF		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 concrete ceiling/roof. Door is metal door. Snow blower has been relocated for storage. Area no longer contains combustibles, does not open in 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 enclose area behind the dryers has be removed for access from the sprinklers already installed in the laundry area. 2. Items were removed from sprinkler decided in the sprinkler of the sprinkler. Activity staff were educated or importance of keeping any obstructions/stored items clea in an area 18" from the bottom sprinkler heads located in that area. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: No	e a. and a s nto y e sed en the mning n the red n of	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155831	B. WI	NG		06/03/	2021
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	EHABILITATION CENTER		SOUTH	BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					other areas of non-compliance		
					were noted after survey round	S.	
					Areas noted have not been		
					modified or changed since ope	-	
					construction and initial Life Sa	iety	
					inspection prior to opening	_	
					facility. Corrections have been made to meet current survey	ı	
					requirements that are not		
					grandfathered into the facility	at	
					opening.	41	
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place: Results of the Life	:	
					Safety Survey have been revie	ewed	
					by the QAPI committee.		
					Maintenance Director/ Design		
					continues to schedule sprinkle	r	
					inspections as required. Any		
					findings of non-compliance wil		
					reported to the QAPI committee	ee	
					for recommendation.		
					By what date the systemic		
					changes will be completed: 6/25/2021		
					0/23/2021		
K 0354	NFPA 101						
SS=F	Sprinkler System	- Out of Service					
Bldg. 01	Sprinkler System						
		ler system is impaired, the					
		on of the impairment has					
	been determined,	areas or buildings involved					
		d risks are determined,					
	recommendations	s are submitted to					
	management or d	lesignated representative,					
		tment and other authorities					
	having jurisdictior	n have been notified. Where					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	<u>01</u>	COMPI	LETED
		155831	B. W	ING	_	06/03	/2021
NAME OF F	AN OLUBER OR GURNI IER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C.		5024 W	ESTERN AVENUE		
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH	BEND, IN 46619		_
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
		em is out of service for more 24-hour period, the					
		of the building affected are approved fire watch is					
		sprinkler system has been					
	returned to service	-					
		, 9.7.5, 15.5.2 (NFPA 25)					
		view and interview, the facility	K 0	354	This plan of Correction is the		06/25/2021
		written policy containing	110		facility's credible allegation of		00,25,2021
	_	llowed for the protection of 55			compliance.		
	_	e event the automatic sprinkler			Preparation and/or execution	of	
	system has to be pla	aced out-of-service for 10			this plan of correction does no	ot	
	hours or more in a 2	24-hour period in accordance			constitute admission or agree	ment	
	with LSC, Section 9	9.7.5. LSC 9.7.5 requires			by the provider of the truth of	the	
	sprinkler impairmer	nt procedures comply with			facts alleged or conclusions s	et	
		ition, the Standard for the			forth in the statement of		
		and Maintenance of			deficiencies. The plan of		
		rotection Systems. NFPA 25,			correction is prepared and/or		
		procedures that the			executed solely because it is		
	_	ator shall follow. This deficient			required by the provisions of		
	practice could affect	t all occupants in the facility.			federal and state law.		
	F' 1' ' 1 1				This facility respectfully reque		
	Findings include:				paper compliance for this citat		
	Dagad on magand nor	view on 06/03/21 at 12:59 p.m.			What Corrective action(s) wi	11	
		ce Director (MD), the facility			be accomplished for those residents found to have been	_	
		h Policy and Procedure			affected by the deficient	11	
	1 ~	it was incomplete. The Fire			practice: No residents were		
		rocedure plan only contacted			identified as being affected by	this	
	I	authorities once the Sprinkler			alleged deficient practice.		
		to normal service. This was			How other residents having	the	1
	l ⁻	ewed with the Administrator			potential to be affected by th		
	during the exit conf	erence.			same deficient practice will l		
					identified and what correctiv		
	3.1-19(b)				actions(s) will be taken: All		
					residents have the potential to	be	
					affected by this alleged deficie	ent	
					practice. The Fire Watch Poli	-	
					has been revised to include al	II the	
					entities be notified after fire		

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	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BUILDING B. WING	01	COMPLETED 06/03/2021
	PROVIDER OR SUPPLIEF	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				systems are restored that are notified when the system is our order as per regulation. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The revised Fire Watch Policy will presented to the QAPI commit for review and approval. Management staff will be educ on the changes made to the F 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 printo place: Fire Watch Policy and Procedure will be reviewed the QAPI committee and update policy will be included in the Emergency Procedure Binders and reviewed annually. By what date the systemic changes will be completed: 6/25/2021	to be ttee cated ire he ut d by tted
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extil 18.3.5.12, 19.3.5.	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10			
	failed to ensure 1 or	on and interview the facility f 1 fire extinguishers observed h the gauge indicator reading	K 0355	This plan of Correction is the facility's credible allegation of compliance.	06/25/2021

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2021	
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION NEDA 10, 2010 Edition	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
IAU	in the operable zone states at 7.2 2 (3) prindicator in the operable zone deficient practice constaff. Findings include: Based on observation with the Administration (MD), the ABC por (#6) next to the Nurred indicator as discitled time of observation the fire extinguisher have to be replaced.	e. NFPA 10, 2010 Edition ressure gauge reading or rable range or position. This rould affect 10 residents and on on 06/03/21 at 3:37 p.m. tor and Maintenance Director table fire extinguisher labeled sing station was showing the charged. Based on interview at tion, the MD acknowledged rewas discharged and would This was discussed with the gethe exit conference.	IAU	Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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 requestigate paper compliance for this cital what Corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice: No residents were identified in this alleged deficipractice. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions(s) will be taken: Residents and staff located in area of this fire extinguisher have potential of being affected this alleged deficient practice. The fire extinguisher located in area of this fire extinguisher located in the 300-400 nurses' station have been replaced. What measures will be put in 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 in this extinguisher in this extinguisher in this extinguisher in the potential of the proper condition. This extinguisher in this extinguisher in the proper condition. This extinguisher in this extinguisher in the proper condition. This extinguisher in this extinguisher in the proper condition.	of ot ment the et st tion. ill n ent the he be re the ave by hear as nto
1			I	ı	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/03/2021
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD WESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION DATE
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postriers shall be postrium wall. Smoke in duct penetration systems where an is installed for smoto the smoke barriers 19.3.7.3, 8.6.7.1(1	nall be constructed to a sance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.		not been discharged, but of pressure was no longer in green area. Any notations extinguishers not passing inspection will be reported QAPI committee and extinwill be replaced. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place: QAPI committee reviewed the results of Life Survey and correction of a QAPI committee will review findings of non-compliance extinguishers and note any recommendations. By what date the systemic changes will be complete 6/25/2021	to the guisher (s) (re the the the the the the the the the th
	system in REMAR				

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NXNK21 Facility ID: 013420

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ſ ′		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155831	B. W	ING	_	06/03/2021	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ESTERN AVENUE		
BRIARCL	.IFF HEALTH & RE	HABILITATION CENTER			I BEND, IN 46619		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID	T	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1710		on and interview, the facility	K 0		This plan of Correction is the	06/25/2021	_
		f 8 smoke barriers observed	K U	312	facility's credible allegation of		1
		a 1/2 hour fire resistive rating			compliance.		
		s caused by the passage of			Preparation and/or execution	of	
	_	the smoke barrier walls was			this plan of correction does no	ı	
		in the smoke resistance of			constitute admission or agree		
	•	LSC Section 19.3.7.5 requires			by the provider of the truth of		
		e constructed in accordance			facts alleged or conclusions s		
		.5 and shall have a minimum ½			forth in the statement of	-	
		ating. This deficient practice			deficiencies. The plan of		
		dents, visitors and staff.			correction is prepared and/or		
		,			executed solely because it is		
	Findings include:				required by the provisions of		
	S				federal and state law.		
	Based on observation	ons on 06/03/21 during the			This facility respectfully reque	sts	
		o.m. to 4:30 p.m. with the			paper compliance for this citat		
	Administrator and I	Maintenance Director (MD),			What Corrective action(s) wi		
	the following areas	had penetrations in smoke			be accomplished for those		
	barriers which were	not sealed or improperly			residents found to have been	ı	
	sealed with foam:				affected by the deficient		
	a. Yellow foam use	ed to seal around four conduits			practice: No residents were		
	penetrating block w	valls in Laundry located in the			identified in this citation.		
	basement.				How other residents having	the	
		or next to Electric room had			potential to be affected by the	е	
		penetrating block wall and			same deficient practice will be	oe e	
	orange foam was us	sed to seal around			identified and what correctiv	е	
	penetrations.				actions(s) will be taken: All		
		basement there were numerous			residents have the potential to		
		g the block wall and yellow			affected by this alleged deficie	ent	
		eal around penetrations.			practice.		
		areas in the Basement storage			a. Areas noted that do not		
	area had conduits of				have a fire rated "Fire Foam"		
		k walls and yellow and orange			"Fire Caulk" have been sched		
		eal around penetrations.			to have the foam removed and		
	_	cross from room #507 used			replaced with "Fire Caulk". A		
	foam to seal around				temporary waiver request has		
		to Therapy used foam to seal			been submitted to allow up to	90	
		work on East side of wall.			days to correct.		
		00 hall next to Nursing station,			What measures will be put in	nto	
	had a large pipe per	netrating wall and the gap was			place or what systemic		

PRINTED: 07/01/2021 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY LETED 3/2021
	PROVIDER OR SUPPLIEF	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP CO VESTERN AVENUE H BEND, IN 46619	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE PROPRIATE	(X5) COMPLETION DATE
	to seal around a one top of the wall and wires penetrating the foam was used to so Based on interview observation with the a through h were all	smokewall used orange foam e inch diameter conduit at the to the right there was TMC are wall and a bright yellow eal the opening. concurrent with each a Administrator and MD, items a confirmed. This was a Administrator during the exit		changes will be made to ensure that the deficient practice does not recursive any penetrations not being filled with fire rate caulk/foam have been filled fire caulk. Maintenance Director/designee will in contractor work that involve penetrating any smoke proper sealing of new penetrations. Results of repairs/corrections of smooth barrier penetrations will reported to the QAPI contraction to the QAPI contraction of the quality assurance program will into place: Any new construction, repairs, and maintenance that involve penetration of a smoke inspected and corrected for compliance. The QAC committee will review reany further recommendary what date the syste changes will be completed for completed will be completed for systems.	nt r: Smoke inspected of noted as d illed with spect any olves barriers for f noke be mmittee. ion(s) issure the not ill be put id/or es wall will be if required API sports for ations. mic	
K 0511 SS=F Bldg. 01	complies with NFF Code, electrical w					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/03/2021 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5024 WESTERN AVENUE **BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND, IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 K 0511 06/25/2021 This plan of Correction is the facility failed to ensure 1 of 1 electrical receptacles facility's credible allegation of observed was protected accordance with NFPA compliance. 70, National Electrical Code. NFPA 70, 2011 Preparation and/or execution of Edition, Article 406.6, Receptacle Faceplates this plan of correction does not (Cover Plates), requires receptacle faceplates shall constitute admission or agreement be installed so as to completely cover the opening by the provider of the truth of the and seat against the mounting surface. This facts alleged or conclusions set deficient practice could affect only staff. forth in the statement of deficiencies. The plan of Findings include: correction is prepared and/or executed solely because it is Based on observation on 06/03/21 at 3:07 p.m. required by the provisions of with the Administrator and Maintenance Director federal and state law. (MD), one electrical wall outlet in the This facility respectfully requests Maintenance office was missing a plate cover. paper compliance for this citation. Based on interview at the time of observation, the What Corrective action(s) will MD confirmed the receptacle cover plate was be accomplished for those missing and said it would be an easy fix. This was residents found to have been discussed with the Administrator during the exit affected by the deficient conference. practice: No residents were identified in this citation. 2. Based on observation and interview, the How other residents having the facility failed to ensure 1 of 1 areas observed, potential to be affected by the protected electrical wiring according to NFPA 70, same deficient practice will be 2011 Edition. Article 406.5 (F) Exposed Terminals, identified and what corrective Receptacles shall be enclosed so that live wiring actions(s) will be taken: Staff terminals are not exposed to contact. This and residents in the areas noted deficient practice could affect only staff. have the potential to be affected by the alleged deficient practice. Findings include: What measures will be put into place or what systemic Based on observation on 06/03/21 at 3:16 p.m. changes will be made to with the Administrator and Maintenance Director ensure that the deficient (MD), there were exposed electrical wires jutting practice does not recur: out of a metal conduit next to the staff desk on Outlet cover was replaced vacant 200 hall. Based on interview at the time of in the Maintenance Office.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155831	B. WI		<u>01</u>	06/03/2021	
		100001	D. WI	140		00/03/2021	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					/ESTERN AVENUE		
BRIARCL	_IFF HEALTH & RE 	HABILITATION CENTER		SOUTH	I BEND, IN 46619		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	1
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		O acknowledged the exposed			· Wiring on closed unit wa		
		fined in an electrical junction			completed as maintenance wa		
		ate. This finding was			process of installing new lighti	-	
		Administrator during the exit			in this area. Wiring was not liv	•	
	conference.				and posed no exposure to inju	ry.	
					· Electrical panels on the		
	3.1-19(b)				nonpopulated area of facility h	ave	
					been secured.		
		ation and interview, the			Staff were educated on the		
		sure 1 of 9 corridors with			importance of identifying any		
	_	nels were secured from			areas that may be noted as no	•	
	-	sonnel per LSC 19.5.1.1. LSC			having outlet covers installed		
	19.5.1.1 states utilities shall comply with the				in good condition or signs of a	•	
	•	on 9.1. LSC 9.1.2 states			electrical wiring that is expose		
	_	d equipment shall be in			populated areas of the facility.		
		FPA 70, National Electrical			Team is advised to report any		
		ction 110.27(A) states live parts			findings of noncompliance to t	he	
		nent over 50 volts or more shall			Maintenance Director or		
		accidental contact by			Administrator for timely		
		or by any of the following			correction/repair. Any findings		
		ion in a room, vault, or similar			noncompliance will be reporte		
		cessible only to qualified			the QAPI committee for review	<i>l</i> .	
		ent practice could affect any			How the corrective action(s)	h	
	residents, Visitors at	nd staff exiting 100 vacant hall.			will be monitored to ensure t	ne	
	Findings include:				deficient practice will not		
	Findings include:				recur, i.e., what quality		
	Rased on observation	on on 06/03/21 at 2:40 p.m.			assurance program will be p		
		ator and Maintenance Director			into place: Survey findings w		
		o electrical circuit panels			reviewed by the QAPI commit Any findings of noncompliance		
		idor wall on 100 vacant hall			be presented to the QAPI	2 AAIII	
		ured against non-authorized			committee for review and		
		n interview during the			recommendations for continue	nd l	
	-	O confirmed the electrical			compliance.	,	
	· ·	red and could be opened by			By what date the systemic		
	-	since they were on a vacant			changes will be completed:		
		atter. This was discussed with			6/25/2021		
		uring the exit conference.			0/20/2021		
	ane rammisuatol u	aring the east conference.					
	3.1-19(b)						

	AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/03/2021	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0521 SS=F Bldg. 01	comply with 9.2 ar accordance with the specifications. 18.5.2.1, 19.5.2.1,		K 0521	This plan of Correction is the	06/25/2021	
	dampers in the facil provided necessary four years in accord 9.2.1 requires heatin conditioning (HVA) equipment shall be A, Standard for the Air-Conditioning ar 90 A, 2012 Edition, dampers shall be man NFPA 80, Standard Opening Protectives Section 19.4.1 state and inspected 1 year 19.4.1.1 states the total shall be every 4 year the frequency is every equipped with a fus removed for testing lock-in-place if so end be blocked from closinspections and test indicating the location inspection, name of discovered. The do space to indicate where the state of the shall be every 4 years and the state of the shall be every 4 years and the shall be every	section 5.4.8.1 states fire aintained in accordance with for Fire Doors and Other s. NFPA 80, 2010 Edition, seach damper shall be tested or after installation. Section est and inspection frequency resexcept for hospitals where ery 6 years. If the damper is ible link, the link shall be to ensure full closure and equipped. The damper shall not essure in any way. All ing shall be documented, on of the fire damper, date of inspector and deficiencies cumentation shall have a men and how the deficiencies is deficient practice could		facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed 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 citate. 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 affected by this alleged deficied practice. Fire damper inspection was scheduled but delayed ductions. Inspection has been constituted in this citation affected by this alleged deficied practice. Fire damper inspections scheduled but delayed ductions.	of t ment the et the e e e be nt on et to	

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	OF CORRECTION	IDENTIFICATION NUMBER 155831	A. BUILDING B. WING	01	COMPLETED 06/03/2021
	ROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	with the Maintenand Fire Damper section there was a single sl words "Done 09/20/ given as to the locat Based on interview the MD stated that v Maintenance Direct	iew on 06/03/21 at 1:15 p.m. the Director (MD), under the state of the Fire Safety logbook the et of writing paper with the 20", no other information was ion, condition, or inspection. Concurrent with record review, was the doing of the previous or. This was discussed with uring the exit conference.		rescheduled. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/assistar were educated on the importation of including vendor documentation the Life Safety binder for fur reference. Vendor has been contacted and is scheduling a inspection date. Documentation of inspection will be entered in the Life Safety Binder for futur reference. Copy of inspection be presented to the QAPI committee for review. How the corrective action(s) will be monitored to ensure a deficient practice will not recur, i.e., what quality assurance program will be previewed citation, correction of citation and education processed ensure against further non-compliance. No further recommendations were provided by what date the systemic changes will be completed: 6/25/2021	nt nce ation ture n on nto re will the ut nas f s to
K 0531 SS=F Bldg. 01	Elevators are insp	with the provision of 9.4. ected and tested as A17.1, Safety Code for			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155831	B. W	ING		06/03/	2021
NAME OF I	DROWIDED OF CUIDNIES		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	X.		5024 W	ESTERN AVENUE		
	LIFF HEALTH & RE	HABILITATION CENTER	SOUTH BEND, IN 46619				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	BEFFERET		DATE
		calators. Firefighter's ed monthly with a written					
	record.	d monthly with a written					
		conform to ASME/ANSI					
		de for Existing Elevators					
	1	ll existing elevators, having					
	a travel distance o	of 25 feet or more above or					
		at best serves the needs of					
		nnel for firefighting					
	1 ' '	n 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						
	_	chine room smoke					
		vator lobby smoke					
	detectors.)	Tale. 1022y cilione					
	19.5.3, 9.4.2, 9.4.3	3					
	Based on observation	on, record review and	K 0	531	This plan of Correction is the		06/25/2021
		ty failed to maintain testing of 1			facility's credible allegation of		
		ghter recall in accordance with			compliance.		
		ing. LSC 9.4.6.2 states that all			Preparation and/or execution		
		ighters' emergency operations			this plan of correction does no		
		9.4.3 shall be subject to a			constitute admission or agree		
		with a written record of the kept on the premises as			by the provider of the truth of facts alleged or conclusions s		
	~	A17.1/CSA B44, Safety Code			forth in the statement of	Cι	
		scalators. This deficient			deficiencies. The plan of		
		et all residents, visitors, and			correction is prepared and/or		
	staff.	, ,			executed solely because it is		
					required by the provisions of		
	Findings include:				federal and state law.		
					This facility respectfully reque		
		on on 06/03/21 at 1:45 p.m.			paper compliance for this citat		
		ntor and Maintenance Director			What Corrective action(s) wi	II	
	1 ' '	had a key access fire			be accomplished for those	_	
	department recall feature. Based on record review with the MD there was no documentation of a				residents found to have been	n	
		recall test for the past year.			affected by the deficient practice: No residents were		
		with the MD, when asked			identified in this citation.		
	= assa sh mich , lew	, ubiteu	1		idontinod in tino ottation.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155831	B. W	ING		06/03/	/2021
		<u> </u>		OTEN DEEM	ADDRESS CITY STATE TO SEE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
DD: 4 D 2:	IEE I IE AV TU A DE	CLIABILITATION CENTED	5024 WESTERN AVENUE				
I RKIAKCI	JIFF HEALTH & RE	EHABILITATION CENTER	SOUTH BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE.	COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VIE.	DATE
		w it was indicated there was no			How other residents having	the	
	_	the monthly firefighter recall			potential to be affected by the		
		ator in the facility. This was			same deficient practice will I		
	_	Administrator during the exit			identified and what corrective		
	conference.	C			actions(s) will be taken: This		
					deficient practice could affect		
	3.1-19(b)				elevator is for service staff on		
	,				Maintenance Director/ design	-	
					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 in	nto	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Monthly testing will be complete	ted	
					and documentation will be log		
					with copies in the Life Safety	god	
					binder and a copy available in	the	
					elevator mechanical room.		
					How the corrective action(s)		
					will be monitored to ensure		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place: Copies of monthly		
					testing will be presented to the		
					QAPI committee by the	-	
					Maintenance Director for 2		
					months. The plan will be ada	nted	
					or adjusted as need to mainta		
					compliance.	1	
					By what date the systemic		
					changes will be completed: 6/25/2021		
					0/23/2021		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BUIL	A. BUILDING <u>01</u> C) DATE SURVEY COMPLETED 06/03/2021	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5024 WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PR	ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulation Smoking Regulation Smoking Regulation shall include not be provisions: (1) Smoking shall ward, or compartnous liquids, combustibused or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care of smoking is prohibit prominently placed secondary signs where smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the purposition. (5) Ashtrays of notes a smoking is (6) Metal contained devices into which shall be readily averaged.	ons ons ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with O SMOKING or shall be ternational symbol for no occupancies where ted and signs are d at all major entrances, with language that prohibits be required. Itients classified as not be prohibited. Int of 18.7.4(3) shall not attent is under direct Incombustible material and one provided in all areas permitted. Its with self-closing cover of ashtrays can be emptied ailable to all areas where		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	interview, the facility cigarette butts were outdoor areas where occurred. This defi	riew, observation and ty failed to ensure extinguished properly disposed of in 1 of 1 e evidence of smoking cient practice could affect e the outside smoking	K 074	1	This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the facts alleged or conclusions see	t ment the	06/25/2021

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/03/2021	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	5024 V	ADDRESS, CITY, STATE, ZIP COD VESTERN AVENUE H BEND, IN 46619	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	Based on review of policy on 06/03/21 Maintenance Direct permitted on the pre Based on observation MD on 06/03/21 at staff outside the Clobutts in two large placed goods. Furthermore were observed on the interview concurrer Administrator was a had been disposed of	the facility's written smoking at 12:22 p.m. with the or (MD), staff smoking is emises outside the Closed unit. on with the Administrator and 2:39 p.m., the smoking area for osed unit deposited cigarette lastic containers with paper e, at least 23 cigarette butts are pavement. Based on at with the observation the disappointed cigarette butts of improperly. This was Administrator during the exit	TAG	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 reque paper compliance for this cital What Corrective action(s) where accomplished for those residents found to have been affected by the deficient practice: No residents were identified in this citation. How other residents having potential to be affected by the same deficient practice will identified and what corrective actions(s) will be taken: Staff could be affected by this alleged deficient practice. An extras moke pot was ordered for the staff smoking area. Trash can were removed from the smok area and a metal fire can was installed for butt disposal. Staff that smoke have been education the proper maintenance of assigned smoking area. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff smoking area is designated to area on property. Smoke pot and a metal fire can have been installed in the immediate are cigarette butt disposal. Trash cans are relocated to adjacent can be a canse and can be adjacent canse are relocated to adjacent c	the he be re f hed he has hing haff hed haft he has hing haff he had

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/03/2021 155831 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **5024 WESTERN AVENUE BRIARCLIFF HEALTH & REHABILITATION CENTER** SOUTH BEND. IN 46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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 K 0761 This plan of Correction is the 06/25/2021 interview, the facility failed to ensure annual facility's credible allegation of inspection and testing of 5 of 5 fire door compliance. assemblies were completed in accordance with Preparation and/or execution of LSC 19.1.1.4.1.1. Communicating openings in this plan of correction does not dividing fire barriers required by 19.1.1.4.1 shall be constitute admission or agreement permitted only in corridors and shall be protected by the provider of the truth of the by approved self-closing fire door assemblies. facts alleged or conclusions set

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(See also Section 8.3.) LSC 8.3.3.1 Openings

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

required to have a fire protection rating by Table

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forth in the statement of

deficiencies. The plan of

correction is prepared and/or

executed solely because it is

required by the provisions of

This facility respectfully requests

paper compliance for this citation.

federal and state law.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u>01</u>	COMPLETED
		155831	B. W	TNG		06/03/2021
NAME OF D	PROVIDER OR SUPPLIER	,	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	NOVIDER OR SUPPLIER	•			/ESTERN AVENUE	
BRIARCI	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH	H BEND, IN 46619	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	1	s, except as otherwise			What Corrective action(s) wi	II
		de. NFPA 80 5.2.1 states fire			be accomplished for those	
		all be inspected and tested not			residents found to have been	n
		and a written record of the			affected by the deficient	
	_	signed and kept for inspection			practice: No residents were	
	1 -	80, 5.2.3.1 states functional			identified in this citation.	
		and window assemblies shall			How other residents having	
		dividuals with knowledge and			potential to be affected by th	
	_	e operating components of			same deficient practice will I	
		ng subject to testing. NFPA			identified and what corrective	re
	80, 5.2.4.1 states fire door assemblies shall be				actions(s) will be taken: All	
	visually inspected from both sides to assess the				residents and staff in the facili	-
	overall condition of door assembly.				have the potential to be affect	
					by this alleged deficient practi	
		tates as a minimum, the			The Maintenance Director has	
	following items sha				added the fire rating tag inspe	
		or breaks exist in surfaces of			to the annual door inspection	-
	either the door or fr				What measures will be put in	nto
		light frames, and glazing beads			place or what systemic	
		ely fastened in place, if so			changes will be made to	
	equipped.				ensure that the deficient	
		, hinges, hardware, and			practice does not recur: A	
		eshold are secured, aligned,			current inspection of fire doors	5
		er with no visible signs of			was completed, and the	
	damage.	. 1 1			documentation of inspection v	
	(4) No parts are mis	9			placed in Life Safety binder fo	r
		do not exceed clearances			reference. Results of this	
	listed in 4.8.4 and 6				inspection will be presented to	tne
	1 ' '	device is operational; that is,			QAPI committee for	
		pletely closes when operated			review/recommendation of	
	from the full open p				inspection.	
	1 ' '	is installed, the inactive leaf			How the corrective action(s)	
	closes before the ac				will be monitored to ensure to	ine
	1 ' ' -	are operates and secures the			deficient practice will not	
	door when it is in the				recur, i.e., what quality	
		vare items that interfere or			assurance program will be p	
		re not installed on the door or			into place: The QAPI commi	
	frame.	*			will review the citation and the	
	, ,	ications to the door assembly			revised inspection documenta	
	have been performe	ed that void the label.			for compliance. The next and	nual

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2021	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		5024 W	ADDRESS, CITY, STATE, ZIP COD ESTERN AVENUE I BEND, IN 46619		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include:			TAG	inspection will be placed on the QAPI agenda for review for the May 2022 QAPI committee rep By what date the systemic changes will be completed: 6/25/2021	€	DATE
	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.						
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthis for 4 continuous hours. der load conditions include					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 01 COMPLETE			LETED
		155831	B. W	TNG		06/03	/2021
NAME OF T	DOMINED OF CHIRD TER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	· ·			ESTERN AVENUE		
	LIFF HEALTH & RE	HABILITATION CENTER		SOUTH BEND, IN 46619			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		rces (Type 3 EES) are in		TAG			DATE
		NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
	1 ' -	tablished according to					
	manufacturer requ	uirements. Written records					
		nd testing are maintained					
	1	ble. EES electrical panels					
		arked, readily identifiable,					
	I	n normal power circuits.					
	Minimizing the possibility of damage of the						
	emergency power source is a design consideration for new installations.						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,					
		review and interview, the	K 0	918	This plan of Correction is the		06/25/2021
		plement the emergency power			facility's credible allegation of compliance.		
		testing, and maintenance					
		in the Health Care Facilities			Preparation and/or execution		
		and Life Safety Code in			this plan of correction does no		
		CFR 483.73(e)(2). This			constitute admission or agree		
	and visitors.	ould affect all residents, staff,			by the provider of the truth of the facts alleged or conclusions set		
	and visitors.				forth in the statement of	El	
	Findings include:				deficiencies. The plan of		
	<i>5</i>				correction is prepared and/or		
	Based on review of	generator Weekly Test Log on			executed solely because it is		
		.m., with the Maintenance			required by the provisions of		
		ast weekly inspection of the			federal and state law.		
	~	5/21. Based on interview at the			This facility respectfully reque		
		ew, the Administrator			paper compliance for this cita		
		weekly inspections on the			What Corrective action(s) wi	II	
	1 -	onsistent. This was discussed ator during the exit conference.			be accomplished for those residents found to have been	n	
	with the Administra	nor during the exit conference.			affected by the deficient	11	
	3.1-19(b)				practice: No residents were		
					identified in this citation.		
	2. Based on record review and interview, the				How other residents having	the	
		plement the emergency power			potential to be affected by th		
	system inspection, t	testing, and maintenance			same deficient practice will I	oe .	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET			ETED	
		155831	B. WI	NG		06/03/	2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			VESTERN AVENUE		
BRIARCI	I IFF HFAI TH & RF	HABILITATION CENTER			H BEND, IN 46619		
Bran area		THE DETERMINATION OF THE PROPERTY OF THE PROPE		00011	1 52115, 111 10010		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	*	l in the Health Care Facilities			identified and what correctiv	е	
		and Life Safety Code in			actions(s) will be taken:		
		2 CFR 483.73(e)(2). This			Residents, staff and visitors ha		
	_	ould affect all residents, staff,			the potential to be affected by	the	
	and visitors.				alleged deficient practice.		
					Maintenance Director and		
	Findings include:				Assistant Maintenance Director		
	l				have been educated on the st	-	
		f generator Monthly Load Test			to complete a weekly inspection	on of	
	-	12:05 p.m., with the			the generator and document		
		tor (MD) the last monthly load			findings on the Generator week	-	
		enerator was 04/07/2021. Based			inspection log. Also instructed		
		time of record review, the MD			process of completing monthly		
	_	monthly load tests on the			load tests and documenting th		
	-	peen done for May of 2021.			results on the Generator Mont	hly	
		with the Administrator during			Load Test log.		
	the exit conference	•			What measures will be put in	ito	
	2.1.10(1)				place or what systemic		
	3.1-19(b)				changes will be made to		
					ensure that the deficient		
					practice does not recur: Res		
					of weekly and monthly reports	WIII	
					be reviewed monthly by the		
					Administrator/designee for		
					timeliness and compliance.		
					Administrator signature of app		
					must be a part of documentati Any findings of noncompliance		
					will be addressed with correct		
					and re-education if necessary		
					presented to the QAPI commi		
					for review and recommendation		
					How the corrective action(s)	/II.	
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place: Weekly inspection		
					and monthly load tests will be	•	
					reviewed monthly and signed	hv	
I	I		I		1	~ y	1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155831		A. BUILDI B. WING		01	COMPLI 06/03/	ETED	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	50	024 WE	DDRESS, CITY, STATE, ZIP COD ESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREI TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
					the Administrator/designee. An findings of non-compliance will presented to the QAPI committ for review and recommendation By what date the systemic changes will be completed: 6/25/2021	be tee	
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-tern do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity, non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(Based on observation failed to ensure prop multi plugs in of 1 as	ed electrical equipment	K 0920		This plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of	of	06/25/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155831	B. W	NG		06/03/	2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ESTERN AVENUE		
BRIARCI	IFF HEAI TH & RE	HABILITATION CENTER			BEND, IN 46619		
DI (I) (I (OL	- TIENETT WILL	LINDIETT/TTON GENTER		000111			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and staff.				this plan of correction does no		
					constitute admission or agree		
	Findings include:				by the provider of the truth of t		
					facts alleged or conclusions se	et .	
	Based on observations on 06/03/21 during the				forth in the statement of		
	tour between 12:09 p.m. to 3:46 p.m. with the				deficiencies. The plan of		
	Administrator and Maintenance Director (MD), a				correction is prepared and/or		
	power strip or multi plug were improperly used in				executed solely because it is		
	the following areas:				required by the provisions of		
	a. A multi plug was used in the Dining room to				federal and state law.	,	
	power a juice machine and coffee maker when the				This facility respectfully reques		
	outlet available was capable of powering the two				paper compliance for this citat		
	appliances without a multi plug. This was				What Corrective action(s) will	ıl	
	corrected at the tim				be accomplished for those		
		ti plug was used the Medical			residents found to have beer	1	
	_	wer a mini refrigerator and a			affected by the deficient		
	power strip.				practice: No residents were		
		concurrent with the he Administrator and MD, it			identified in this citation.	u	
					How other residents having t		
	_	the multi plug in item (a) was x prong multi plug was not			potential to be affected by th		
		uld not be used. This finding			same deficient practice will be		
		the Administrator and MS			identified and what correctiv	e	
	during the exit conf				actions(s) will be taken: Residents, staff or visitors in the	20	
	during the exit com	terence.			vicinity of the alleged deficient		
	3.1-19(b)				practices have the potential to		
	3.1-19(0)				affected. Staff have been	ne	
					educated on the importance of	f	
					reporting any type of electrical		
					multi-plug observed in the faci		
					immediately to their supervisor		
					Maintenance Director or	,	
					Administrator.		
					What measures will be put in	ito	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur: The	,	
					multiplugs were immediately		
					removed. Inspections were		
	l		1		·		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155831		A. BUILDING <u>01</u> B. WING			COMPLETED 06/03/2021	
		133631	b. w	_		00/03/	72021	
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD			
DDIADCI	IEE HEALTH & DE	LIADII ITATION CENTED			ESTERN AVENUE			
BRIARCLIFF HEALTH & REHABILITATION CENTER			SOUTH	I BEND, IN 46619				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					completed of remaining popul	ated		
					areas of facility with no other			
					findings of non-compliance no			
					Inspection of resident rooms r	nulti		
					plugs was added to the list of			
					items to check on in the Guard			
					Angel program. Guardian Ang	•		
					will check rooms a minimum o			
					weekly for any multi plug devi			
					Any findings of non-compliand must be corrected and reported			
					the Maintenance Director time			
					This will remain a part of the	лу.		
					Guardian Angel program.			
					Education for resident/families	:		
					may be required.			
					How the corrective action(s)			
					will be monitored to ensure			
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place: The results of this	;		
					citation were reviewed and			
					discussed by the QAPI			
					committee. Any findings of			
					non-compliance will be reported			
					the QAPI Committee for revie	W		
					and recommendations.			
					By what date the systemic			
					changes will be completed:			
	l		1		6/25/2021		1	

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