STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING -- B. WING	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/06/2025 Facility Number: 013302 Provider Number: 155824 AIM Number: 201281730 At this Emergency Preparedness survey, Wellbrooke of South Bend was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey, the census was 50. Quality Review completed on 03/10/25	E 0000	The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on 2/11/2025. Please accept this Plan of Correction as Wellbrooke of South Bend credible allegation of compliance effective 2/28/2025. The Provider respectfully requests a desktop review for the health campus with paper compliance to be considered in establishing the provider is in substantial compliance.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	Compliance Date 3/21/2025 Immediate Intervention The Executive Director has conducted a Facility-based Table-top exercise. Also, the Executive Director has scheduled a community-based exercise about medical emergency with	03/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karl Steinhaus	ED	03/21/2025

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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	155824	A. BUILDING -- B. WING	03/06/2025

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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Director of Plant Services from 9:30 a.m. to 12:05 p.m. on 03/06/25, the facility failed to provide documentation of a table-top exercise or a full-scale community-based exercise, a facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan. Based on interview at the time of record review the Director		local EMT's in July of 2025 The Executive Director was educated by Facilities Management Support on E039 – The LTC facility must conduct exercise to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The Executive Director will review the facilities Emergency Operations Plan (EOP) 1 X per quarter with the Director of Plant Operations and Facilities Management Support assuring that the facilities is conducting a facility-based and a community-based exercise testing the EOP. Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors.	

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	155824	A. BUILDING -- B. WING	03/06/2025

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	of Plant Services provided a document with severe weather information definitions. The document did not mention activation of the facility's emergency preparedness plan, a time of activation or what procedures were followed. This finding was reviewed with the Executive Director and Director of Plant Services at the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/06/2025 Facility Number: 013302 Provider Number: 155824 AIM Number: 201281730 At this Life Safety Code survey, Wellbrooke of South Bend, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This two-story facility was determined to be of Type V (111) construction and fully sprinklered. Separation between the first-floor healthcare occupancy and the second-floor residential occupancy is provided by a horizontal floor/ceiling assembly with a 2-hour Fire Resistive Rating. The rated floor/ceiling system is	K 0000	The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on 2/11/2025. Please accept this Plan of Correction as Wellbrooke of South Bend credible allegation of compliance effective 2/28/2025. The Provider respectfully requests a desktop review for the health campus with paper compliance to be considered in establishing the provider is in substantial compliance.	

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	155824	A. BUILDING 01 B. WING	03/06/2025

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	supported by 2 hour rated construction. The Southwest wing of the first floor is a residential occupancy; however, is not separated from the healthcare facility by a 2-hour fire barrier and is therefore surveyed as healthcare. The building is partially protected by a 300-kW diesel gas-powered generator. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridors. The facility has hard-wired smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 50 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/10/25			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 2 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect residents, staff and visitors on the memory care unit. Findings include:	K 0293	K293 – Exit Signage Compliance Date: 4/1/2025 Immediate Intervention The Director of Plant has installed No Exit signage to the door that leads to the outside of the Memory Care unit. The Director of Plant Operations was educated by the Executive Director on LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way to exit access and is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as	04/01/2025

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	Based on observation and interview with the Executive Director and Director of Plant Services from 12:07 p.m. to 2:28 p.m. on 03/06/25, an all glass door that appeared to lead outside from the memory care unit was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observation, the Director of Plant Services stated the door led to the courtyard and is not an exit to a public way and only provided access to an enclosed courtyard for residents on the memory care unit. This finding was reviewed with the Executive Director and Director of Plant Services at the exit conference. 3.1-19(b)		"NO EXIT" The Director of Plant of Plant Operations will conduct an audit of the door leading to the outside located in the Memory Care unit 1 X per week X 4 weeks assuring that the appropriate signage remains in place. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect residents, staff and visitors on the Memory Care Unit.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of	K 0324	The Director of Plant Operations has installed approved caster placement devices to the floor, assuring that the cookline equipment is in proper alignment with the fire extinguishing system (ANSUL). The Director of Plant Operations was educated by the Executive Director on NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved designed location.	03/27/2025

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	maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff. The findings include: Based on observation and interview with the Executive Director and Director of Plant Services from 12:07 p.m. to 2:28 p.m. on 03/06/25, cooking appliances including a gas burner stove and oven, with a flat-top grill, a deep fryer, and gas grill, were located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Executive Director, he stated he was aware of the requirement but not aware of any method or procedure in place for the facility. This finding was reviewed with the Executive Director and Director of Plant Services at the exit conference. 3.1-19(b)		The Director of Plant Operations will audit the cookline equipment assuring proper alignment with the fire extinguishing system. 1 X per week X four weeks. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect kitchen staff.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm	K 0345	K345 – Fire Alarm System – Testing and Maintenance Compliance Date 03/24/2025	03/24/2025

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	Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Director of Plant Services from 9:30 a.m. to 12:05 p.m. on 03/06/25, a fire alarm system inspection document titled "Fire/Life Safety System Inspection Testing and Maintenance" was dated 04/16/2024; however, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. At the time of record review the Director of Plant Services stated: "Since switching to New Era they only do annual testing." This finding was reviewed with the Executive Director and Director of Plant Services at the exit conference. 3.1-19(b)		Immediate Intervention The Director of Plant has scheduled semi-annual fire alarm visual inspection with New Era The Director of Plant Operations was educated by the Executive Director on NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6 NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1. The Executive Director will review all fire alarm inspection once every six months X 1 year with the Director of Plant Operations and Facilities Management Support assuring that the inspections completed as required by the standard. Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff and visitors.	
K 0923 SS=F	NFPA 101 Gas Equipment - Cylinder and Container			

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Bldg. 01	Storag Based on observation and interview, the facility failed to ensure oxygen cylinders were properly stored in accordance with NFPA 99. NFPA 99 section 11.6.5.2 states if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could effect all residents and staff. Findings include: Based on observation and interview with the Executive Director and Director of Plant Services from 12:07 p.m. to 2:28 p.m. on 03/06/25, the oxygen storage and transfilling room located in the 100 hall contained 3 E- size oxygen cylinders and 4 liquid oxygen bulk containers. 1. Based on observation both full and empty oxygen cylinders and bulk containers were not segregated. 2. Empty cylinders and containers were not marked to avoid confusion and delay if a cylinder is needed in a rapid manner. Based on interview at time of observation, the Executive Director and Director of Plant Services acknowledged empty and full oxygen cylinders and bulk containers were not segregated and no signage or other method was available to identify empty cylinders and containers. This finding was reviewed with the Executive Director and Director of Plant Services at the exit conference. 3.1-19(b)	K 0923	Compliance Date 03/24/2025 Immediate Intervention The Director of Plant Operations has installed signage in the oxygen storage and transfilling room the reads “FULL” “EMPTY” to avoid confusion and delay if a cylinder is needed in a rapid manner. The Director of Plant Operations was educated by the Executive Director on NFPA 99 section 11.6.5.2 states if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a cylinder is needed in a rapid manner. The Director of Plant Operations will audit oxygen storage and transfilling room assuring that the “EMPTY” and “FULL” cylinders remain segregated 1 X per week X 4 weeks. Results of this review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect all residents, staff.	03/24/2025