

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 17, 18, 19, 20, 23, 2012</p> <p>Facility number: 000073 Provider number: 155153 AIM number: 100288820</p> <p>Survey team: Bobbie Costigan, RN TC Vicki Manuwal, RN Susan Bruck, RN Sandra Haws, RN (1/17/12 through 1/19/12)</p> <p>Census bed type: 128 SNF/NF 128 Total</p> <p>Census payor type: 22 Medicare 84 Medicaid 22 Other 128 Total</p> <p>Sample: 24</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0458 SS=D	<p>Quality review completed 1/26/12 Cathy Emswiller RN</p> <p>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on record review and interview, the facility failed to provide at least 80 square feet per resident in 8 multiple resident rooms. (Rooms 109, 110, 156, 158, 209, 210, 256, and 258).</p> <p>Findings include:</p> <p>During record review on 1/18/12 at 9:30 a.m., the following multiple resident rooms were identified to contain less than 80 square feet per resident:</p> <p>*Room 109 SNF/NF, 2 beds, 150.33 total square feet. 75.17 square feet per resident.</p> <p>*Room 110 SNF/NF, 2 beds, 150.33 total square feet. 75.17 square feet per resident.</p> <p>*Room 156 SNF/NF, 2 beds, 155 total</p>	F0458	<p>This plan of correction also represents the facility's allegation of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations.</p> <p>Futhermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law. The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.F-458- The facility received approval for requested waiver of CFR 42 483.70(d)(1) (ii). Rooms 109, 110, 209, 210, 156, 158, 256, 258 are waived. The waiver remains in place at</p>	01/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>square feet. 77.5 square feet per resident.</p> <p>*Room 158 SNF/NF, 2 beds, 155.9 total square feet. 78 square feet per resident.</p> <p>*Room 209 SNF/NF, 2 beds, 150.33 total square feet. 75.17 square feet per resident.</p> <p>*Room 210 SNF/NF, 2 beds, 150.33 total square feet. 75.17 square feet per resident.</p> <p>*Room 256 SNF/NF, 2 beds, 155 total square feet. 77.5 square feet per resident.</p> <p>*Room 258 SNF/NF, 2 beds, 155.9 total square feet. 78 square feet per resident.</p> <p>During an interview with the Administrator on 1/18/12 at 9:30 a.m. she indicated the measurements of the above rooms were accurate and did not provide at least 80 square feet per resident.</p> <p>3.1-19(l)(2)</p>		<p>the time of the survey. No negative outcomes related to room size have occurred. The facility is currently under construction and will be in a position to eliminate some if not all waived rooms from existence once construction is completed.</p>		