

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2012
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NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/20/12</p> <p>Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Healthwin was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility with a basement was determined to be of Type II (222) construction and is not sprinklered. The facility is in the process of having a complete automatic sprinkler system installed. The facility has a fire alarm system with smoke detection in the</p>	K0000	<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. Furthermore, 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.</p>	
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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.

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	<p>corridors and all areas open to the corridor. Battery operated smoke detectors are installed in all of the resident rooms. The facility has a capacity of 143 and had a census of 121 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0017 SS=E	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5			
	Based on observation and interview, the facility failed to ensure 2 of 5 open areas were separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or meet an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully fully developed fire is unlikely to occur and (c) The space	K0017	A door with a door closer was installed on 3/1/12 on the copy room on the second floor of the east wing. An electronically supervised automatic smoke detector was installed in the copy room and the Blue room in the Northwest wing on 3/1/12. A waiver is being submitted to request time for the completion of the in-process installation of the automatic sprinkler system. Anticipated completion date is 7/1/12. The smoke detectors are hardwired into the alarm system that is monitored 24 hours per day by Healthwin, ADT, and the Clay Township Fire Department. This monitoring system is ongoing. The maintenance logs and inspection reports will be reviewed in the Safety Committee and the Safety reports are reviewed in the Quality Assurance Committee that meets quarterly.	03/01/2012

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	<p>is arranged not to obstruct access to required exits. This deficient practice could affect any resident, staff or visitor in the vicinity of the areas not separated from the corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator during a tour of the facility at 11:45 a.m. to 2:30 p.m. on 02/20/12, the copy room on the second floor east wing lacked a door separating the room from the corridor and the Blue room located on the first floor northwest wing lacked a wall separating the room from the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because both areas were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Director acknowledged the areas were not protected by an electrically supervised smoke detection system.</p> <p>3.1-19(b)</p>			
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K0022 SS=B	<p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 paths of egress in the basement was marked with approved signs to make the direction of travel to reach the nearest exit apparent. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice affects staff in the basement.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director and Administrator on 02/20/12 from 11:45 a.m. to 2:30 p.m., the basement corridors lacked exit signs that would indicate the direction of exit travel to the exit stairwells. Exit signs above the stairwell exit doors were the only exit signs provided. Based on interview at the time of observation, the Maintenance Director acknowledged the only exit signs provided in the basement were those located at the stairwells.</p> <p>3.1-19(b)</p>	K0022	<p>Glow in the dark Exit Direction signs were installed on 3/5/12 in the paths of egress in the basement to ensure the direction of travel to reach the nearest exit stairwell is apparent. In-services will be conducted on 3/6 and 3/7/12 for all staff to inform them of the Exit directions and the Stairwell Exits. Safety In-services are conducted for all staff upon hire General Orientation and annually for all staff. The Director of Environmental Services and the Staff Development Coordinator are responsible for the in-servicing and monitoring of this information.</p>	03/09/2012	

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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near the hazardous areas.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Administrator on 02/20/12 between 11:45 a.m. and 2:30 p.m., the following was noted:</p> <p>a) The second floor soiled utility room on the northwest wing which was being used for storage of five soiled linen and trash barrels, it had a door closer but it did not latch into the door frame.</p> <p>b) The central supply room located on the second floor physical therapy was being used for storage of combustibile material, exceeded 50 square feet in area and the door lacked a door closer.</p>	K0029	<p>The second floor soiled utility room on Northwest was repaired to latch into the door frame on 2/28/12. The central supply room located on the second floor physical therapy wing was repaired with a door closer and assurance of latching into the door frame on 2/28/12. The first floor soiled utility room on the west wing was repaired to latch into the door frame on 2/28/12. The oxygen storage room door was repaired with a door closer and assurance of latching into the door frame on 2/28/12. The dietary paper goods storage room was repaired with a door closer and assurance of latching into the door frame on 2/28/12. An audit will be conducted to assess all areas in need of door closers and latches on 3/7/12. This regulation will be inserviced with the Maintenance Department on 3/6 and 3/7/12. The facility has a door latch audit in place and will continue to audit monthly and the information will be reviewed in the</p>	03/09/2012			

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	<p>c) The first floor soiled utility room on the west wing was being used for storage of five soiled linen and trash barrels and had a door closer, but it did not latch into the door frame.</p> <p>d) The oxygen storage room door lacked a door closer.</p> <p>e) The dietary paper goods storage room exceeded 50 square feet and the door lacked a door closer.</p> <p>Based on interview during the times of observation, the Maintenance Supervisor acknowledged the doors to these rooms either did not latch into the frame or lacked a door closer.</p> <p>3.1-19(b)</p>		Safety Committee and reports submitted to the Quality Assurance Committee that meets quarterly.				

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K0048 SS=B	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.7.2.2 states a written facility fire safety plan shall provide for:</p> <p>(a) Use of alarms, (b) Transmission of alarm to fire department, (c) Response to alarms, (d) Isolation of fire, (e) Evacuation of immediate area, (f) Evacuation of smoke compartment (g) Preparation of building for evacuation (h) Extinguishment of fire.</p> <p>This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility's written policy titled "Fire Plan-Fire Extinguishers" provided by the Administrator on 02/20/12 at 3:50 p.m., the plan did not address the use of the K Class portable fire extinguisher located in the kitchen. Specifically, excerpts from the policy stated, "Our fire extinguishers</p>	K0048	Healthwin's "Fire Plan-Fire Extinguisher Policy was updated on 3/5/12 to address the use of the K Class portable fire extinguisher located in the kitchen to provide for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats.)This policy will be in-serviced to all staff on 3/6 and 3/7/12. This policy will be in-serviced upon hire in General Orientation of all new employees and annually in the Emergency and Disaster In-service.The Human Resource Director and Staff Development Coordinator are responsible to ensure that all employees are educated and trained on the Fire Plan - Fire Extinguisher Policy.	03/09/2012			

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	<p>can be used on any type of fire" and "Our fire extinguishers again are of the ABC type and can put out all types of fire." The Administrator during the time of review, acknowledged the written policy did not address the use of the K Class portable fire extinguisher located in the kitchen.</p> <p>3.1-19(b)</p>			

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K0050 SS=C	<p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills at unexpected times under varying conditions in 3 of 4 third shift fire drills. This deficient practice affects all residents in the facility including staff.</p> <p>Findings include:</p> <p>Based on review of fire drill documentation with the Maintenance Director and Administrator from 2:30 p.m. to 3:45 p.m., three of the four fire drills conducted on the third shift were conducted within one hour from each other as follows: 03/21/11 at 11:15 p.m., 09/30/11 at 11:00 p.m., and 12/29/11 at 11:30 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged these third shift fire drills were conducted within one hour from each other.</p> <p>3.1-19(b) 3.1-51(c)</p>	K0050	An updated schedule of Fire Drills for 2012 was completed on 3/2/12 to ensure that fire drills are conducted at unexpected times and under varying conditions. The drills include drills over a 24 hour time period and 7 days per week of the year to be conducted by the Environmental Services Director. The Fire Drill reports will be reviewed in the Safety Committee and reports are reviewed in the Quality Assurance Committee that meets quarterly. The Director of Environmental Services is responsible for the conducting and completion of fire drills and reporting.	03/02/2012			

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K0064 SS=B	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect mostly staff while working in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/20/12 from 11:45 a.m. to 2:30 p.m. with the Maintenance Director and Administrator</p>	K0064	A placard was conspicuously placed near the Class K Fire Extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher on 3/6/12. The placard information and Class K Fire Extinguisher information will be in-serviced to all staff on 3/6 and 3/7/12. This information will be in-serviced to all employees upon hire in General Orientation and annually in the Emergency and Disaster Preparedness in-service. The Director of Environmental Services is responsible for the installation and maintenance of the placard, and the Staff Development Coordinator is responsible for the education of this information, policy and procedures.	03/09/2012			

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	<p>during a tour of the facility, there was a Class K portable fire extinguisher in the kitchen which lacked a placard. Based on interview at the time of observation, the Maintenance Director acknowledged the Class K portable fire extinguisher lacked a placard.</p> <p>3.1-19(b)</p>			

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K0130 SS=E	<p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Administrator on 02/20/12 during the tour from 11:45 a.m. to 2:30 p.m., there was a rolling fire door protecting the opening between the Alcove serving area and the corridor. Based on interview with the Maintenance Director at the time of observation, there was no additional documentation of an annual inspection or test to check for proper operation and full closure.</p>	K0130	The rolling fire door protecting the opening between the Alcove serving area and corridor has been scheduled with Overhead Door Company for inspection and testing to ensure the door to be working properly to ensure proper operation and full closure on 3/8/12. A documentation form was created to show inspection and ongoing annual inspections. This annual inspection will be placed on the Preventative Maintenance List. The Preventative Maintenance list and audits are reviewed in the Safety Committee and reviewed in the Quality Assurance Committee that meets quarterly. The Director of Environmental Services is responsible for this inspection, test, and documentation.	03/09/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2012
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
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K0144 SS=F	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 2 generators met the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. NFPA 110, 6-4.2.2 states diesel powered EPS installations that do not meet the requirements of NFPA 110, 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of generator load testing</p>	K0144	A Full Load Bank test is scheduled to be conducted on the Cummins generator on 3/7/12. Documentation on the generator load testing will be updated and reviewed by 3/9/12. The Generator load tests will be reviewed in the Safety Committee and reports reviewed in the Quality Assurance Committee that meets quarterly. The Director of Environmental Services is responsible for this testing and maintaining proper documentation of all testing.	03/09/2012	

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	documentation with the Maintenance Director from 2:30 p.m. to 3:50 p.m. on 02/20/12, the Cummins generator runs under load at 45.2 amps and thirty percent of the Cummins generator's load capacity is 63 amps. Based on interview during the time of record review, the Cummins generator is diesel powered and the Maintenance Director acknowledged the facility has not exercised the Cummins generator annually with supplemental loads. 3.1-19(b)			