

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<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 Dates: 07/25/16</p> <p>Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820</p> <p>At this Life Safety Code survey, Healthwin was found in not 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in areas open to the corridors and in 9 of 122 resident rooms. Battery operated smoke detectors were in</p>	K 0000	<p>This plan of correction also represents the facility's allegations 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 alleged deficiencies or violations. Furthermore none of the actions taken by the plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiencies. 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 of violation existed.</p>	
------------------------	---	--------	--	--

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 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0018 SS=E Bldg. 01	<p>112 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 127 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered.</p> <p>Quality Review on 07/27/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 131 corridor doors did not have an impediment to latching. This deficient practice could affect staff and up to 27 residents.</p>	K 0018	Corrective Action: It is the policy of Healthwin to prevent impediments that would prevent the closing of doors. The nurse call cord, which had been wrapped around the handrail outside of resident room 119 was	08/26/2016

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 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0020 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation and interview on 07/25/16 at 11:41 a.m., the Chief Financial Officer and the Maintenance Supervisor acknowledged the corridor door to resident room 119 had the call light cord wrapped around the corridor railing which impeded the door from latching.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 East vertical openings were enclosed with</p>	K 0020	<p>removed. The resident in Room 119 has been provided a personal pendant call light that does not require a cord. The staff and resident residing in room 119 have been instructed concerning the potential safety issues caused by wrapping the call cord around the handrail. How Others Identified/Corrective Action: No additional door closure impediments were identified. Preventive Measures Put In Place: An in-service shall be conducted with all staff pertaining to the identification and prevention of door closure impediments. Monitoring and QI: Identified door closure impediments will be documented as a part of the monthly door audits that are currently conducted. The Maintenance Supervisor is responsible for the completion and oversight of the audits. The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that all vertical openings are enclosed with construction having at least a</p>	08/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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>construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect staff and at least 21 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:22 a.m., the East stairway contained eight penetrations ranging from three quarters of an inch to one inch. The Paint room opens into the East stairwell. The door to the Paint room contained a mesh opening measuring eight inches to 36 inches. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p>		<p>one hour fire rating. The penetrations in the unoccupied, third floor, East stairwell, leading to the roof, have been patched and sealed. The mesh opening in the Paint Room door has also been sealed. How Others Identified/Corrective Action:No additional penetrations were identified. Ongoing repairs and renovations affecting smoke barriers will be reviewed by the Maintenance Supervisor to ascertain smoke/fire barriers are maintained. Preventive Measures Put In Place: An in-service shall be conducted with the Maintenance Staff pertaining to Fire Safety and the identification and corrections of penetrations in vertical openings and fire door assemblies. Monitoring and QI: All renovations affecting fire rated enclosures and fire door assemblies performed by staff or outside workers will be inspected by the Maintenance Supervisor or Designee. Inspection results will be presented to the QI Committee on a quarterly basis.</p>		

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0021 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and</p> <p>(b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</p> <p>(c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 East vertical openings contained self-closing doors. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1(c) requires openings in the separation shall be protected by the fire door assemblies equipped with door</p>	K 0021	<p>Corrective Action: It is the policy of Healthwin to ensure that all vertical openings contain self-closing doors, as required. A self-closing mechanism has been installed on the East Stairwell door leading to the penthouse. How Others Identified/Corrective Action: _No additional doors were identified that required, but did not contain, self-closing mechanisms Preventive</p>	08/26/2016

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 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0025 SS=D Bldg. 01	<p>closures complying with 7.2.1.8. This deficient practice could affect staff and up to 21 residents.</p> <p>Findings include:</p> <p>Based on observations with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:22 a.m., the East Stairwell contained a door leading up to the penthouse. The door failed to self-close and latch when tested. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an</p>	K 0025	<p>Measures Put In Place: Self-closing mechanisms are and will be tested during monthly door audits that are currently conducted. Monitoring and QI: _The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis. The Maintenance Supervisor is responsible for the completion and oversight of the audits.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that ceiling smoke barriers are maintained to ensure at least a ½ hour fire resistance rating. The ceiling penetration in resident room 125 closet and the penetrations in the housekeeping office have been</p>	08/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0029 SS=E Bldg. 01	<p>outside wall. This deficient practice could affect staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observations with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:35 a.m. then again at 1:03 p.m., there were ceiling penetrations ranging from two and a half inches to three inches in resident room 125 closet. Then again, there were three separate one inch ceiling penetrations in the Housekeeping office. Based on interview at the time of each observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p>		<p>sealed and patched. How Others Identified/Corrective Action: No additional penetrations of smoke barriers were identified. Ongoing repairs and renovations affecting smoke barriers will be reviewed by the Maintenance Supervisor to ascertain smoke/fire barriers are maintained. Preventive Measures Put in Place: An in-service will be conducted for the Maintenance Department pertaining to Fire Safety and the necessity for maintaining smoke barriers. Monitoring and QI: All renovations affecting smoke barriers, either performed internally or by outside workers will be inspected by the Maintenance Supervisor or Designee to ascertain that smoke barriers are maintained. Inspection results will be presented to the QI Committee on a quarterly basis.</p>				

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 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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>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 the corridor door to 1 of 1 fuel fired Boiler room and 1 of 1 fuel fired Kitchen, both hazardous areas, would positively latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:55 a.m. then again at 1:11 p.m., one of Kitchen doors failed to latch when tested. Then again, the Boiler room corridor door failed to latch when test. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>Corrective Action: It is the policy of Healthwin to ensure that smoke resisting doors in hazardous areas are protected by a self-closing door that positively latches into the frame. The main dining room double doors have been adjusted to properly latch into the frame. The Activity storage area has been reorganized and one of the double doors has been permanently locked, which eliminates the need to install a coordinating closing device. How Others Identified/Corrective Action: No additional doors requiring adjustments were identified. Preventive Measures Put in Place: Door audits are conducted on a monthly basis and doors requiring adjustments are documented and corrected to ensure proper latching into the door frame. Monitoring and QI: The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis.</p>	08/26/2016			
K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 East stairwell exit was readily accessible and</p>	K 0038	<p>Corrective Action: It is the policy of Healthwin to ensure that all exits are readily accessible.</p>	08/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0043 SS=E Bldg. 01	<p>unobstructed at all times. This deficient practice could affect staff and up to 31 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:22 a.m., the East stairwell contained twenty four HVAC filters, four holiday wreaths, and a ladder. Based on an interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged such that the patients can open the door from inside without using a key.</p> <p>Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5 Based on observation, the facility failed to ensure 1 of 1 Bridgeview restroom doors with a lock installed was arranged such that staff have keys at all times. LSC 19.2.2.5 requires adequate provisions made for the rapid removal of occupants</p>	K 0043	<p>Codes have been posted on the three exit gates located on the Main Dining Room porch. How Others Identified/Corrective Action: No additional doors were identified that did not contain a posted code. Preventive Measures Put in Place: Door audits are conducted on a monthly basis for latching into the door frames, review for impediments, and exit door access, code posting, and usage. An in-service will be conducted for all staff pertaining to Fire Safety, door impediments, proper storage, proper accessibility of exits, and the necessity for maintaining coding on exit doors. Monitoring and QI: The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis. This is the responsibility of the Maintenance Supervisor.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that staff has access to keys required to unlock resident accessible rooms and restrooms. The bathroom door locks for rooms 255, 253, 249, and 251 have been</p>	08/26/2016	

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0044 SS=E Bldg. 01	<p>by means available to staff at all times. This deficient practice could affect staff and up to 43 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 10:55 a.m., the Bridgeview restroom across from resident room 288 contained a lock. The Clerk at the Bridgeview nurses' station was unable to locate a key to unlock the door. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 5 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to</p>	K 0044	<p>removed. How Others Identified/Corrective Action: All resident bathrooms with similar locks have been removed.</p> <p>Preventive Measures Put in Place: An in-service will be conducted for the entire staff pertaining to the location of keys required to unlock resident accessible rooms and restrooms.</p> <p>Monitoring and QI: The results of the in-service and system location of keys for restrooms and resident accessible rooms will be presented to the QI Committee. The Director of Environmental Services is responsible for this key system.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that all fire doors automatically close and latch. The fire doors near room 101 were adjusted to ensure proper closing and latching, prior to the completion of the life safety survey. How Others</p>	08/26/2016

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 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0048 SS=E Bldg. 01	<p>be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 31 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:43 p.m., the fire doors near resident room 101 failed to close and latch when tested. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 1. Based on record review and interview,</p>	K 0048	<p>Identified/Corrective Action: All other fire doors automatically closed and latched. Preventive Measures Put in Place: Door audits are conducted on a monthly basis and doors requiring adjustment are documented and corrected to ensure proper latching into the door frame. An in-service will be conducted with the Maintenance Department to emphasize the proper auditing and closure of Fire Doors and latching into the door frame.</p> <p>Monitoring and QI: The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis. Door audits and compliance are the responsibility of the Maintenance Supervisor.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that our</p>	08/26/2016			

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 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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>the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect staff and up to 48 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 between 10:02 a.m. and 2:09 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a fire barrier. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based</p>		<p>written fire plan appropriately addresses all required standards. The written fire policy has been amended to clarify the difference between fire/smoke doors and separation doors. The written fire policy, as written at the time of the life safety survey, did contain language pertaining to removal of obstacles in the exit paths. The written fire plan has also been amended to contain specific reference to wheeled equipment.</p> <p>How Others Identified/Corrective Action: Based upon review of the written fire plan, no additional amendments were needed. Preventive Measures Put in Place: An in-service will be conducted for all staff pertaining to Fire Safety and presentation of the amended Fire Policy which includes the difference between fire doors and separation doors, as well as removal or relocation of wheeled obstructions in exit paths.</p> <p>Monitoring and QI: The amended written fire plan will be practiced in the monthly fire drills and presented to the QI Committee. The Director of Environmental Services is responsible for completion of the Fire Plan, training, and compliance.</p>				

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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>on observation at 10:30 a.m., the North West Center set of doors were not a complete barrier. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide a written plan that addressed relocation of wheeled equipment during an emergency. NFPA 101 19.2.3.4(4) (b) requires health care occupancies have a safety plan and training program. This deficient practice could affect staff and up to 27 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16, the facility had a written fire policy. The policy did not include response to items stored in the corridor. Based on observation at 10:35 a.m., a wheeled equipment was stored in the corridor in West 2. Based on interview at observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p>			

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 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0051 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the Reception area was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the</p>	K 0051	Corrective Action: It is the policy of Healthwin to ensure that smoke detectors located near air handling systems are properly installed and located to prevent an adverse affect of the operation of the detector. The smoke detector is scheduled to be relocated so that it is no closer	08/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0062 SS=F Bldg. 01	<p>detectors. This deficient practice could affect staff and 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 12:53 p.m., the Reception area had a smoke detector located twenty four inches away from an HVAC vent. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent</p>	K 0062	<p>than three feet from the air vent. How Others Identified/Corrective Action: Based upon review, all other smoke detectors have been installed in accordance with established standards. Preventive Measures Put in Place: An in-service will be conducted for the Maintenance Department pertaining to Fire Safety and the proper positioning and installation of smoke detectors. Monitoring and QI: All renovations affecting smoke detectors performed by outside workers will be inspected by the Maintenance Supervisor or Designee to ascertain that smoke detectors are properly installed. Inspection results will be presented to the QI Committee on a quarterly basis.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that the automatic sprinkler system is maintained in a reliable operating condition and inspected and tested periodically. The gauge on the sprinkler pipe near the incinerator room is scheduled to be replaced. How Others Identified/Corrective Action: Based upon review, no other</p>	08/26/2016	

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 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0064 SS=D Bldg. 01	<p>of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 1:09 p.m., the sprinkler pipe located near the Incinerator had one gauge installed. The gauge indicated it was manufactured in August 2010. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 Maintenance Shop portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers</p>	K 0064	<p>gauges required replacement.</p> <p>Preventive Measures Put in Place: Gauges will be replaced by an outside contractor, as required based upon operating condition and or age. Education on the gauge requirements will be included in an in-service for the Maintenance Department. Monitoring and QI: A replacement plan will be established with an outside contractor to ensure all components will be tested and replaced in accordance with established guidelines. This is the responsibility of the Director of Environmental Services. The replacement plan will be presented to the QI Committee.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that fire extinguishers are installed correctly, accessible, and properly maintained. The fire extinguisher near the maintenance shop door has been remounted to a height no more than 60 inches from the floor. How Others</p>	08/26/2016	

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 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0076 SS=E Bldg. 01	<p>weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 06/25/16 at 1:05 p.m., a Maintenance shop fire extinguisher measured 65 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99),</p>		<p>Identified/Corrective Action: An audit was conducted pertaining to fire extinguisher height. Fire extinguishers mounted in excess of 60 inches from the floor were lowered to be no more than 60 inches.</p> <p>Preventive Measures Put in Place: An in-service will be conducted for the maintenance staff pertaining to fire safety and mounting requirements for fire extinguishers. Monitoring and QI: Fire extinguisher audits are conducted on a monthly basis under the responsibility of the Maintenance Supervisor. The results of the monthly audits will be presented to the QI Committee, on a quarterly basis.</p>				

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 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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>18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders in the East 2 Nurses' station and 1 of 7 cylinders in the oxygen transfill room supply of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff and up to 24 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 11:05 a.m. then again at 12:13 p.m., the East 2 Nurses' station had one oxygen cylinder that was freestanding on the floor. Then again, the oxygen transfill room had one oxygen cylinder that was freestanding on the floor. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0076	<p>Corrective Action: It is the policy of Healthwin to ensure that all oxygen containers are properly stored and secured. The oxygen cylinder on East 2 Unit at the Nurses Station and the oxygen cylinder in the trans-fill room were properly secured prior to the completion of the life safety survey. How Others Identified/Corrective Action: All other oxygen cylinders were properly secured. Preventive Measures Put in Place: An in-service will be conducted for all staff pertaining to the proper storage and handling of oxygen cylinders. An audit of stored oxygen is conducted on a monthly basis. Monitoring and QI: The results of the monthly audits will be presented to the QI Committee on a quarterly basis. Proper Oxygen storage and audits are the responsibility of the Maintenance Supervisor.</p>	08/26/2016	

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 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0130 SS=E Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance</p>	K 0130	<p>Corrective Action: It is the policy of Healthwin to ensure that fire barrier walls are maintained to resist fire. The identified penetrations on the West 1 and West 2 fire barriers were filled and sealed. How Others Identified/Corrective Action: No additional penetrations of fire barriers were identified. Ongoing repairs and renovations affecting smoke barriers will be reviewed by the Maintenance Supervisor or Designee to ascertain smoke/fire barriers are maintained.</p> <p>Preventive Measures Put in Place: An in-service will be conducted for the Maintenance Department pertaining to Fire Safety and the necessity for maintaining fire barriers.</p> <p>Monitoring and QI: All renovations affecting fire barriers, either performed internally or by outside workers will be inspected by the Maintenance Supervisor or Designee to ascertain that smoke barriers are maintained. Inspection results will be presented to the QI Committee on a quarterly basis.</p>	08/26/2016			

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0144 SS=C Bldg. 01	<p>of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff and up to 49 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 1:32 p.m. then again at 1:45 p.m., the East 2 fire barrier contained three separate one half inch unsealed penetrations inside conduit above the ceiling tile. Then again, the East 1 fire barrier contained two separate one half inch unsealed penetrations above the ceiling tile. Based on interview at the time of each observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6</p>			

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 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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>(NFPA 110) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 9:34 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on</p>	K 0144	<p>Corrective Action: It is the policy of Healthwin to ensure that the emergency generator is maintained and tested in accordance with established standards. The cool down period will be documented as requested by the surveyor. It should be noted that the documentation form as supplied the ISDH does not contain a specific line item referencing the cool down period, nor is the cool down period documented on the example supplied by the ISDH. Also it should be noted the generator is programmed so that it will not allow a shutdown until the engine is properly cooled. How Others Identified/Corrective Action: None. Preventive Measures Put in Place: The documentation form will be updated to document the cool down period as requested by the surveyor. The Maintenance Department will be in-serviced on this documentation. Monitoring and QI: The monthly generator log book will be reviewed by the QI Committee on a quarterly basis. The Maintenance Supervisor is responsible for operation and the documentation of the Emergency Generator.</p>	08/26/2016	

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0147 SS=E Bldg. 01	<p>interview at the time of record review, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug and 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 1:00 p.m. then again at 1:03 p.m., a multiplug powering a surge protector powering computer equipment in the Basement Housekeeping office. Then again, an</p>	K 0147	<p>Corrective Action: It is the policy of Healthwin to ensure that flexible electrical cords are not used as a substitute for fixed wiring. The multi-plug used in the housekeeping office and the extension cord temporarily in use in the maintenance shop to power the dehumidifier have been removed and are no longer in use. The electrical box cover in the Medical Records room and the cover on the electrical box above the ceiling near the Northwest fire barrier have been secured. How Others Identified/Corrective Action: No additional flexible electrical cords or multi-plugs were discovered to be in use in place of permanent wiring. No additional exposed wiring was discovered.</p> <p>Preventive Measures Put in Place: An in-service shall be conducted for all staff concerning the proper use of electrical cords,</p>	08/26/2016

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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>extension cord powering a dehumidifier in the Maintenance Shop. Based on interview at the time of each observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Medical Records and 1 of 1 NW 2 fire barrier electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 1:15 p.m. then again at 1:53 p.m., there was exposed wiring in a junction box without a cover in the Medical Record storage room. Then again there was exposed wiring in a junction box without a cover above the</p>		<p>power cords, and surge protectors. An in-service will be conducted for the Maintenance Department pertaining to Fire Safety and the necessity for maintaining electrical wire protection.. Monitoring and QI: All renovations affecting electrical wiring, either performed internally or by outside workers will be inspected by the Maintenance Supervisor or Designee to ascertain that electrical wiring protections are maintained. Inspection results will be reviewed by the QI Committee on a quarterly basis.</p>	

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 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0000 Bldg. 02	<p>ceiling tile near the NW 2 fire barrier. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <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 Dates: 07/25/16</p> <p>Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820</p> <p>At this Life Safety Code survey, Healthwin was found in not 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) and 410 IAC 16.2. The 2012 addition was surveyed with</p>	K 0000	<p>This plan of correction also represents the facility's allegations 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 alleged deficiencies or violations. Furthermore none of the actions taken by the plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiencies. 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 of violation existed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0043 SS=D Bldg. 02	<p>Chapter 18, New Health Care Occupancies.</p> <p>This two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in areas open to the corridors and in 9 of 122 resident rooms. Battery operated smoke detectors were in 112 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 127 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered.</p> <p>Quality Review on 07/27/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5 Based on observation, the facility failed to ensure 4 of 28 West wing doors with a lock installed was arranged such that staff have keys at all times. LSC 18.2.2.5 requires adequate provisions made for the rapid removal of occupants by means available to staff at all times. This deficient practice could affect staff and</p>	K 0043	<p>Corrective Action: It is the policy of Healthwin to ensure that staff has access to keys required to unlock resident accessible rooms and restrooms. The bathroom door locks for rooms 255, 253, 249, and 251 have been removed. How Others Identified/Corrective Action: All resident bathrooms with similar</p>	08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0045 SS=E Bldg. 02	<p>up to 4 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 between 10:02 a.m. and 2:09 p.m., the following was discovered:</p> <p>a) resident room 255 bathroom door had a deadbolt installed</p> <p>b) resident room 253 bathroom door had a deadbolt installed</p> <p>c) resident room 249 bathroom door had a deadbolt installed</p> <p>d) resident room 251 bathroom door had a deadbolt installed</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each aforementioned condition and was unable to locate a key to unlock the bathroom doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8</p> <p>Based on observation and interview, the</p>	K 0045	<p>locks have been removed.</p> <p>Preventive Measures Put in Place: An in-service will be conducted for the entire staff pertaining to the location of keys required to unlock resident accessible rooms and restrooms.</p> <p>Monitoring and QI: The results of the in-service and system location of keys for restrooms and resident accessible rooms will be presented to the QI Committee. The Director of Environmental Services is responsible for this key system.</p> <p>Corrective Action: It is the policy</p>	08/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0130 SS=E Bldg. 02	<p>facility failed to ensure the lighting for 1 of 2 West 1 exits means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect staff and up to 56 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 12:10 p.m., the West 1 exit discharge had only one bulb near the gate lock when leaving the courtyard. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS Miscellaneous</p> <p>List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. THE LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in</p>	K 0130	<p>of Healthwin to ensure that each exit contains adequate exit lighting. A second bulb has been installed at the West 1 exit. How Others Identified/Corrective Action: No other exit lighting issues were identified.</p> <p>Preventive Measures Put in Place: Exit lighting will be monitored and documented on a monthly basis. An in-service for the Maintenance Department will be conducted to include lighting requirements and proper auditing.</p> <p>Monitoring and QI: The results of the monthly exterior exit lighting audits will be reviewed by the QI Committee on a quarterly basis. This is the responsibility of the Maintenance Supervisor.</p> <p>Corrective Action: It is the policy of Healthwin to ensure that fire barrier walls are maintained to</p>	08/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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>1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff</p>		<p>resist fire. The identified penetrations on the West 1 and West 2 fire barriers were filled and sealed. How Others Identified/Corrective Action: No additional penetrations of fire barriers were identified. Ongoing repairs and renovations affecting smoke barriers will be reviewed by the Maintenance Supervisor or Designee to ascertain smoke/fire barriers are maintained.</p> <p>Preventive Measures Put in Place: An in-service will be conducted for the Maintenance Department pertaining to Fire Safety and the necessity for maintaining fire barriers.</p> <p>Monitoring and QI: All renovations affecting fire barriers, either performed internally or by outside workers will be inspected by the Maintenance Supervisor or Designee to ascertain that smoke barriers are maintained. Inspection results will be presented to the QI Committee on a quarterly basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0000 Bldg. 03	<p>and up to 51 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 1:37 p.m. then again at 1:41 p.m., the West 2 fire barrier contained a one and one half inch unsealed penetration above the ceiling tile. Then again, the West 1 fire barrier contained a one inch and a two inch unsealed penetrations above the ceiling tile. Based on interview at the time of each observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <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 Dates: 07/25/16</p> <p>Facility Number: 000073</p>	K 0000	<p>This plan of correction also represents the facility's allegations 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 alleged deficiencies or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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
K 0029 SS=E Bldg. 03	<p>Provider Number: 155153 AIM Number: 100288820</p> <p>At this Life Safety Code survey, Healthwin was found in not 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) and 410 IAC 16.2. The expanded dining room was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in areas open to the corridors and in 9 of 122 resident rooms. Battery operated smoke detectors were in 112 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 127 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered.</p> <p>Quality Review on 07/27/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in</p>		<p>violations. Furthermore none of the actions taken by the plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiencies. 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 of violation existed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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>accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Main Dining room containing more than 64 gallons of soiled linen and or trash, a hazardous area, would positively latch into the frame. This deficient practice could affect staff and at least 25 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 12:23 p.m., the Dining room contained five trash containers totaling more than 64 gallons. The dining room corridor double doors latched into each other but neither of the doors latched into the frame in the Dining room. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>	K 0029	<p>Corrective Action: It is the policy of Healthwin to ensure that smoke resisting doors in hazardous areas are protected by a self-closing door that positively latches into the frame. The main dining room double doors have been adjusted to properly latch into the frame. The Activity storage area has been reorganized and one of the double doors has been permanently locked, which eliminates the need to install a coordinating closing device. How Others Identified/Corrective Action: No additional doors requiring adjustments were identified.</p> <p>Preventive Measures Put in Place: Door audits are conducted on a monthly basis and doors requiring adjustments are documented and corrected to ensure proper latching into the door frame. Monitoring and QI: The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis.</p>	08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(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			
K 0038 SS=E Bldg. 03	<p>the facility failed to ensure the double corridor door to 1 of 1 Main Dining Room Activity Storage room measuring greater than 50 square feet, a hazardous area, had a coordinating device installed. This deficient practice could affect staff and at least 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 12:26 p.m., the Main Dining Room Activity Storage room contained combustible storage of games and activity supplies in quantities making it difficult to get inside the room. The corridor double doors contained an astragal but no coordinating device. Based on interview at the time of observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 Based on observation, record review, and interview, the facility failed to ensure 3</p>	K 0038	Corrective Action: It is the policy of Healthwin to ensure that all	08/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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>of 3 Main Dining room exit discharges had a code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect staff and up to 25 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer and the Maintenance Supervisor on 07/25/16 at 12:22 p.m., three Main Dining room exits were held in the locked position with a magnetic hold down device. Furthermore, the three exit doors were equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted at the entrance/exit door. Based on an interview at the time of each observation, the Chief Financial Officer and the Maintenance Supervisor acknowledged the aforementioned</p>		<p>exits are readily accessible. Codes have been posted on the three exit gates located on the Main Dining Room porch. How Others Identified/Corrective Action: No additional doors were identified that did not contain a posted code. Preventive Measures Put in Place: Door audits are conducted on a monthly basis for latching into the door frames, review for impediments, and exit door access, code posting, and usage. An in-service will be conducted for all staff pertaining to Fire Safety, door impediments, proper storage, proper accessibility of exits, and the necessity for maintaining coding on exit doors. Monitoring and QI: The results of the monthly door audits will be reviewed by the QI Committee on a quarterly basis. This is the responsibility of the Maintenance Supervisor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN			STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637		
(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	
K 0000 Bldg. 04	<p>conditions.</p> <p>3.1-19(b)</p> <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 Dates: 07/25/16</p> <p>Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820</p> <p>At this Life Safety Code survey, Healthwin was found in not 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) and 410 IAC 16.2. The two story Therapy addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with</p>	K 0000	<p>This plan of correction also represents the facility's allegations 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 alleged deficiencies or violations. Furthermore none of the actions taken by the plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiencies. 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 of violation existed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>04</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER HEALTHWIN	STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637
---	--

(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>smoke detection on all levels including in the corridors, in areas open to the corridors and in 9 of 122 resident rooms. Battery operated smoke detectors were in 112 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 127 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered.</p> <p>Quality Review on 07/27/16 - DA</p>			