

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  05/15/2014
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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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K010000	<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: 05/14/14 and 05/15/14</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 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 with the exception of the areas cited at K56. The facility has a fire alarm system with smoke detection on all levels</p>	K010000	<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 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 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.

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K010018 SS=E	<p>including in the corridors, in areas open to the corridors and in 9 of 122 resident rooms. Battery operated smoke detectors were in 113 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 134 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered with the exception of the areas cited at K56. All areas providing facility services were sprinklered with the exception of the areas cited at K56.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed</p>			

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	<p>of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 30 corridor doors on the second floor northwest wing closed and latched into the door frame. This deficient practice could affect at least 10 residents on the second floor northwest wing as well as staff.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer, maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 8:00 a.m. to 10:00 a.m., the door to the former shower room next to the second floor northwest smoke barrier lacked a functioning latching device. Based on interview at the time of observation, the Chief Financial Officer, maintenance staff # 1 and maintenance staff # 2 acknowledged the lack of a latching device on the door for the former shower room which is now used for storage instead of providing showers.</p>	K010018	<p><b>Corrective Action:</b> The 2 sets of double doors into the main dining room have been repaired to close and latch into the frames. <b>How Others Identified/Corrective Action:</b> The Director of Environmental Services will conduct an audit of all corridor doors to ensure they latch into the door frame and repairs will be made to any doors found to not latch into the door frame. This audit includes the Main Dining Room Doors. The results of this audit will be documented on an audit form. <b>Preventative Measures Put in Place:</b> The existing Door Latch Audit form will be updated to include all corridor doors and will also include the Main Dining Room doors. An In-Service will be conducted for all staff on education of Fire Safety and the necessity for doors to latch into the door frame. <b>Monitoring and QI:</b> The Door Latch Audit will be conducted weekly for 3 months and monthly thereafter. Audits will be reviewed in QI monthly x 3</p>	06/14/2014

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K010029 SS=D	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 8 of 15 doors serving hazardous areas such as kitchens, laundries and areas with quantities of combustible materials exceeding 50 square feet closed and latched to prevent the passage of smoke. This deficient practice would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the following was noted:</p> <p>a. The kitchen door near the ambulance</p>	K010029	<p>months and quarterly in the QA meeting thereafter.</p> <p><b>Corrective Action:</b> The kitchen door near the ambulance entrance has been repaired to ensure the door latches into the door frame with each closing. The Laundry room door labeled #14 has been repaired to latch directly into the door frame. The basement Activity storage room door was repaired with a door closer and assurance of latching into the door frame. The basement Housekeeping storage room door was repaired with a door closer and assurance of latching into the door frame. The two basement Medical Records storage room doors were repaired with door closers and assurance of latching into the door frame. The basement Christmas Decoration storage</p>	06/14/2014			

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	<p>entrance did not close properly. The door was provided with a self closer but air pressure kept the door from latching. Based on interview at the time of observation, maintenance staff # 1 acknowledged that when the other kitchen door was opened, the door would close and latch.</p> <p>b. The laundry room door labeled, "#14" was provided with a self closer but the door hit the frame and did not latch. Based on interview at the time of observation, maintenance staff # 1 acknowledged the laundry door was damaged.</p> <p>c. The basement activity storage room door lacked a door closer. This room exceeded 50 square feet and was used for the storage of a large quantity of combustible materials such as cardboard boxes and activity supplies.</p> <p>d. The basement housekeeping storage room door lacked a door closer. This room exceeded 50 square feet and was used for the storage of a large quantity of combustible materials such as cardboard boxes and housekeeping supplies.</p> <p>e. Two of two basement medical records storage room doors lacked a door closer. These two rooms exceeded 50 square feet and were used for the storage of a large quantity of combustible materials such as cardboard boxes and paper medical record files.</p>		<p>room door was repaired with a door closer and assurance of latching into the door frame. The basement Information Technology room door was repaired with a door closer and assurance of latching into the door frame. <b>How Others Identified/Corrective Action:</b> An audit will be conducted to assess all areas in need of door closers and latches. Results of the audit and repairs needed will be documented on the audit form.</p> <p><b>Preventative Measures Put in Place:</b> The existing Door Latch Audit form will be updated to include a list of all Door Closers to be audited. An In-Service will be conducted for all staff on education of Fire Safety, the regulation for door closers and requirements, and the necessity for doors to latch into the door frame. <b>Monitoring and QI:</b> The Door Latch/ Door Closer Audit will be conducted weekly for 3 months and monthly thereafter. Audits will be reviewed in QI monthly x 3 months and in the QA meeting quarterly thereafter.</p>				

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K010046 SS=B	<p>f. The basement Christmas decoration storage room door lacked a door closer. This room exceeded 50 square feet and was used for the storage of a large quantity of combustible materials such as Christmas decorations.</p> <p>g. The Information Technology (IT) room door lacked a door closer. This room exceeded 50 square feet and was used for the storage of a large quantity of combustible materials such as cardboard boxes.</p> <p>Based on interview at the time of observation, maintenance staff # 1 and # 2 acknowledged the doors to the aforementioned rooms did not self close and latch to prevent the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview; the facility failed to ensure 1 of 55 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of</p>	K010046	<b>Corrective Action:</b> The battery operated emergency light in the west center stairwell between the first floor and the basement has been repaired and tested for functioning. <u>How Others</u>	06/14/2014

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	<p>Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor using the west center stairwell.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer, maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 8:00 a.m. to 10:00 a.m., the battery operated emergency light in the west center stairwell between the first floor and the basement did not function when tested. Based on interview at the time of observation, the the Chief Financial Officer, maintenance staff # 1 and maintenance staff # 2 acknowledged the aforementioned battery operated emergency light did not function when tested.</p> <p>3.1-19(b)</p>		<p><b><u>Identified/Corrective Action:</u></b> The 55 battery operated emergency lights will be identified and listed on an audit sheet. The 55 battery operated emergency lights will be tested for function and scheduled ongoing for 30 seconds at 30 day intervals along with the annual test to be conducted on every required battery powered emergency lighting system for a duration of at least 1 1/2 hours. Written records of visual inspections and tests shall be maintained.</p> <p><b><u>Preventative Measures Put in Place:</u></b> A listing of the battery operated emergency lights and an audit has been developed along with the written records required for visual inspections and tests. A schedule has been developed to comply with the function test scheduled for 30 seconds at 30 day intervals. The 30 day function test and annual test shall be kept on a routine schedule to ensure compliance. An In-Service will be conducted for all staff on education of Fire Safety, the regulation for door closers and requirements, and the necessity for doors to latch into the door frame. An In-service for the Maintenance Department will be conducted on Emergency Battery operated Lighting systems and requirements, necessary routine testing requirements for function and safety preparedness.</p> <p><b><u>Monitoring and QI:</u></b> The tests for</p>				

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K010048 SS=F	<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 Based on record review and interview, the facility failed to develop a written fire safety plan to address staff response to the activation of battery operated smoke detectors installed in 113 of 122 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K010048	<p>Battery operated emergency lights, 30 second function test at 30 day intervals will be reviewed in QI monthly x 3 months and in the QA quarterly meeting thereafter. The Annual test will also be reviewed in the QA meeting.</p> <p><b>Corrective Action:</b> The Disaster Plan &amp; Procedure-Fire Plan have been updated to include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. A Fire Drill to assess staff response to activation of a battery operated smoke detector was conducted on 5/21/14. <b>How Others Identified/Corrective Action:</b> The Disaster Plan and Procedure-Fire Plan was updated and a full facility Fire Drill was conducted on 5/21/14 to test staff response to activation of a battery operated smoke detector. This was to test staff response to protect all staff, residents, and visitors. <b>Preventative Measures Put in Place:</b> An In-Service will be conducted for all staff on education of Fire Safety, the updated Disaster Plan and Procedure-Fire Plan, the regulation for door closers and requirements, and the necessity for doors to latch into the door</p>	06/14/2014	

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K010052 SS=F	<p>Based on review of the Disaster Plan &amp; Procedure-Fire Plan documentation with the Chief Financial Officer (CFO) during record review on 05/14/14 at 3:00 p.m., the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in 113 resident sleeping rooms. The policy and procedure stated, "the facility is protected by the automatic fire alarm, heat detector and smoke detector system. Should a fire occur, the fire alarm system will automatically alarm." Based on interview during record review, the CFO acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure</p>	K010052	<p>frame. The Fire Drill schedule will include drills that test the activation of battery operated smoke detectors to ensure staff awareness and safety for staff, residents, and visitors.</p> <p><b>Monitoring and QI:</b> The Fire Drills will be reviewed in QI monthly x 3 months and summarized in the quarterly QA meeting. The Disaster Plan and Procedures will be updated as necessary and reviewed annually for changes and overall review.</p> <p><b>Corrective Action:</b> An annual inspection and testing of the fire alarm system, which included all</p>	06/14/2014			

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	<p>documentation for the testing of 1 of 1 fire alarm system components and devices such as smoke detectors, horn/strobe devices, door holder devices, and fire alarm control equipment was complete. NFPA 72, National Fire Alarm Code, 7-3.2 requires fire alarm system devices such as smoke detectors, fire alarm boxes, horn/strobe devices, door holder devices, and fire alarm control equipment be tested annually. NFPA 72, 7-5.1 says paper or electronic media shall be permitted. Then in 7-5.2.1 it says records shall be retained until the next test and for 1 year thereafter. 7-5.2.2 says a permanent record of all inspections, testing, and maintenance shall be provided. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the 08/09/13 Fire Alarm Inspection and Testing Report with the Chief Financial Officer (CFO) on 05/14/14 at 2:00 p.m., the following was noted:</p> <p>a. The 08/09/13 fire alarm system inspection which was marked as an "Annual" inspection indicated only 8 of 26 pull stations and 18 of 125 photo detectors were tested.</p> <p>b. The 08/09/13 fire alarm inspection</p>		<p>devices, was conducted and completed on May 22, 2014. The written Fire Alarm inspection and Testing Report, which includes a detailed listing of individual devices tested, and sensitivity testing of smoke detectors will be retained as a permanent record.</p> <p><b>How Others Identified/Corrective Action:</b> The annual inspection and testing report was reviewed by the current Director of Environmental Services and the Administrator to verify the completeness of the report. <b>Preventative Measures Put in Place:</b> An inspection and testing of the fire alarm system shall be scheduled and completed on an annual basis. An in-service will be conducted for the maintenance department on the requirements for the annual inspection and necessary documentation. <b>Monitoring and QI:</b> The annual inspection and testing of the fire alarm system shall be reviewed in QA meeting on an annual basis.</p>				

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K010056 SS=E	<p>lacked an itemized list of alarm initiating and supervisory devices with locations and individual test results.</p> <p>c. The smoke detectors in the Alarm Initiating Devices and Circuit Information section of the 06/26/12 Fire Alarm Inspection and Testing Report were listed as "Photo Detectors" and the same smoke detectors on the attached Alarm Inspection Points List were listed as "Ion" detectors.</p> <p>d. The Alarm Inspection Points List attached to the 06/26/12 Fire Alarm Inspection and Testing Report documents the "sensitivity" for the smoke detectors as 1.7 and the "Alarm" as 1.6 These issues were acknowledged by the CFO at the time of record review.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully</p>						

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	<p>supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building for 1 of 2 elevator machine rooms. NFPA 13, Section 5-1.1 states sprinklers shall be installed throughout the premises. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room.</p> <p>LSC Section 9.7.3.1 allows alternative automatic extinguishing systems other than an automatic sprinkler system such as a water mist, carbon dioxide, dry chemical foam or a standard extinguishing system of another type in lieu of an automatic sprinkler system. Such systems shall be installed, inspected</p>	K010056	<p><b>Corrective Action:</b> A complete automatic sprinkler system will be installed in the main elevator machine room, located on the roof and at the bottom of the West stairwell. The installation shall be completed by June 14, 2014. <b>How Others Identified/Corrective Action:</b> No additional areas have been identified that are required to be sprinkled. <b>Preventative Measures Put in Place:</b> No additional areas have been identified that are required to be sprinkled. This will also be reviewed in our Annual Sprinkler Inspection along with the building layout. <b>Monitoring and QI:</b> The Annual Sprinkler Inspection and current building layout will be reviewed annually in the QA meeting.</p>	06/14/2014

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	<p>and maintained in accordance with NFPA standards and shall activate the building fire alarm system. This deficient practice could affect residents, staff and/or visitors using the main elevator.</p> <p>Findings include:</p> <p>Based on observation with the Chief Financial Officer, maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 8:00 a.m. to 10:00 a.m., the main elevator machine room located on the roof lacked sprinkler protection or protection by an alternative extinguishing system. Based on interview at the time of observation, the Chief Financial Officer, maintenance staff # 1 and maintenance staff # 2 acknowledged the lack of extinguishing protection in the main elevator machine room located on the roof.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building for 1 of 6 stairwells. NFPA 13, 5-13.3.2 states in noncombustible stair shafts with</p>						

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K010062 SS=C	<p>noncombustible stairs, sprinklers shall be installed at the top of the shaft and under the first landing above the bottom of the shaft. This deficient practice could affect residents, staff and/or visitors using the west stairwell.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the top of the two story west stairwell was sprinklered but not the bottom of the stairwell. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged the lack of a sprinkler head at the bottom of the west stairwell.</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 provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the</p>	K010062	<b>Corrective Action:</b> A stock of at least six sprinklers, with a minimum of two of each type used in the facility, have been stocked and will be maintained in a cabinet on the premises for	06/14/2014			

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	<p>Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., there were no sidewall sprinklers in the spare sprinkler cabinet. There were sidewall sprinkler heads observed during the tour throughout the facility. The lack of spare sidewall sprinklers was acknowledged by the maintenance staff # 1 and maintenance staff # 2 at the time of observation.</p> <p>3.1-19(b)</p>		<p>replacement purposes. <b>How Others Identified/Corrective Action:</b> The Director of Environmental Services will conduct an audit to ensure that a stock of at least six sprinklers, with a minimum of at least two of each type are maintained.</p> <p><b>Preventative Measures Put in Place:</b> The Director of Environmental Services will conduct an audit to ensure that a stock of at least six sprinkler heads, with a minimum of at least two of each type are maintained. An in-service will be conducted for the maintenance department concerning the necessity to maintain the required inventory of sprinklers. <b>Monitoring and QI:</b> The Sprinkler Inventory Audit will be conducted weekly for 3 months and monthly thereafter. Audits will be reviewed in QI monthly and in the quarterly QA meeting thereafter.</p>	

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K010064 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 35 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any resident or staff using the designated smoking area.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the monthly inspection tag on the fire extinguisher located in the designated</p>	K010064	<p><b>Corrective Action:</b> The fire extinguisher located in the designated smoking area has been replaced with an extinguisher that contains the appropriate documentation of monthly inspection. <b>How Others Identified/Corrective Action:</b> The Director of Environmental Services has conducted an audit to ensure that all fire extinguishers are identified on the Fire Extinguisher Monthly Audit Form and inspected on a monthly basis. <b>Preventative Measures Put in Place:</b> An in-service will be conducted for the maintenance department concerning the necessity to inspect all fire extinguishers on a monthly basis and review required documentation. <b>Monitoring and QI:</b> The Fire Extinguisher Audit will be conducted on a monthly basis. Audits will be reviewed in QI monthly for 3 months and in the quarterly QA meeting thereafter.</p>	06/14/2014

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K010072 SS=E	<p>smoking area lacked documentation of a monthly inspection for the months of November and December of 2013 and January, February, March and April of 2014. This was acknowledged by maintenance staff # 1 at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 2 of 15 exits. This deficient practice could affect at least 20 residents as well as staff and visitors using the west exit.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m.,</p>	K010072	<p><b>Corrective Action:</b> a. The gate outside of the West exit is no longer locked. The gate has been left chained to deter residents from attempting to open the gate and prevent elopement. The chain contains a spring link to allow the gate to be opened in the event of emergency. b. The plastic tubs have been removed from the exit corridor located outside of laundry. <b>How Others Identified/Corrective Action:</b> a. The other gates have been evaluated with this new system and corrected for the need of emergency evacuation. b. An audit was conducted and no other</p>	06/14/2014			

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	<p>the following was noted:</p> <p>a. The gate outside the west exit was locked with a padlock. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged the padlock had recently been replaced and the only key was at the nurses' station.</p> <p>b. Eleven large plastic tubs with a capacity of 16 cubic feet each were stored in the exit corridor outside the laundry. Based on interview at the time of observation, maintenance staff #1 and maintenance staff # 2 acknowledged the plastic tubs were an impediment to the exit.</p> <p>3.1-19(b)</p>		<p>areas were identified for containers or carts stored in an exit corridor. <b>Preventative Measures Put in Place:</b> a. The monitoring of the West gate and Darden Park gates, to ensure that it is accessible, has been added to the duties of the evening janitorial staff. The West gate will be checked on a daily basis. b. The laundry and janitorial staff have been instructed that neither carts or other impediments are to be stored in the exit corridor out of the laundry. The Director of Environmental Services and the Manager of Laundry will ensure neither carts or other impediments are stored in this exit corridor. An in-service will be conducted for the facility to educate the prevention of impediments of the exit corridors. <b>Monitoring and QI:</b> a. The Director of Environmental Services will continue to monitor the completion of duties performed by the janitorial staff. This item will be added to the Preventative Maintenance List which is reviewed monthly in QI and also in the quarterly QA meeting. b. The Director of Environmental Services and the Manager of Laundry will ensure neither carts or other impediments are stored in said corridor. This item will be added to the Preventative Maintenance List which is reviewed monthly in QI and also in the quarterly QA meeting.</p>	

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K010076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 9 of 9 cylinders of nonflammable gases such as oxygen, carbon dioxide, nitrogen, and medical air 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 in the basement.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the following was noted:</p> <p>a. There were two oxygen E-cylinders,</p>	K010076	<p><b>Corrective Action:</b> The two oxygen E-cylinders, two carbon dioxide cylinders, and one cylinder of nitrogen standing on the floor in the hallway across from the former maintenance director's office have been removed from the building. The four large medical air cylinders in the basement cylinder room have been properly secured. <b>How Others Identified/Corrective Action:</b> The Director of Environmental Services shall conduct an audit of all gas cylinders stored in the facility to ensure that all cylinders are properly secured. Documentation of this audit and a list of the location of all cylinders will be created for ongoing audits.</p> <p><b>Preventative Measures Put in Place:</b> An audit form will be developed to audit and monitor the proper securing of all gas cylinders stored in the facility. An in-service will be conducted for the facility on the proper storage</p>	06/14/2014
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K010144 SS=F	<p>two carbon dioxide cylinders and one cylinder of nitrogen standing on the floor in the hallway across from the former maintenance supervisor's basement office. The cylinders were loosely chained to the wall with the chain hanging near the bottom of the cylinders. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged the cylinders were loosely supported and could fall over.</p> <p>b. There were four large medical air cylinders in the basement cylinder room that were freestanding and not supported in a cart or stand or chained. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged the cylinders should be in the nearby cylinder rack.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the</p>	K010144	<p>and securing medical gases. <b>Monitoring and QI:</b> A Medical Gas Cylinder Audit which includes all storage areas for medical gases will be conducted on a weekly basis for three months and monthly thereafter. Audits will be reviewed in QI on a monthly basis and also in the quarterly QA meeting.</p> <p><b>Corrective Action:</b> A 2 hour generator load test is scheduled to be conducted on June 2, 2014. The written results will be</p>	06/14/2014			

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	<p>requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, Health Care Facilities, Chapter 3-4.4.1.1 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>Chapter 6-4.2.2 of NFPA 110, requires diesel-powered EPS installations that do not meet the requirements of Chapter 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.</p> <p>This deficient practice could affect all</p>		<p>documented and available for inspection. A battery powered emergency light has been installed to provide emergency task lighting in and around the Caterpillar generator. <b>How Others Identified/Corrective Action:</b> This generator services the entire building and will be maintained properly per regulations. <b>Preventative Measures Put in Place:</b> An in-service will be conducted with the maintenance department on the regulation, policy and procedure for generator inspection, testing, and documentation requirements. The battery powered emergency lighting has been included on the list of emergency lighting and was tested May 29, 2014 on the 30 day – 30 second emergency lighting function test. <b>Monitoring and QI:</b> The documentation forms for the monthly testing of the generator, and emergency lighting will be reviewed by the Director of Environmental Services monthly in QI and reviewed quarterly in the QA meeting.</p>				

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator - Monthly Test Log with the Chief Financial Officer (CFO) on 05/14/14 at 2:30 p.m., the following was noted:</p> <p>a. The monthly load information for January, February, March, and April was not documented. Additionally, the monthly load test log for January, 2014 through May, 2014 lacked the generator's name plate rating; what 30 % of the generator name plate rating is; the normal operating temperature and the transfer time.</p> <p>b. Documentation of generator load testing was not available for review for the time period of June, 2013 through December, 2013.</p> <p>c. The most recent load bank test occurred two years ago on 05/08/12. Based on interview at the time of record review, the CFO acknowledged the aforementioned issues regarding the generator.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the</p>						

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	<p>generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the Caterpillar generator set was enclosed within a fenced in area and was not provided with a battery powered emergency light for task lighting. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged battery powered emergency task lighting was not provided.</p> <p>3.1-19(b)</p>			

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 basement elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any resident using the east elevator as well as staff.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and # 2 during the tour of the facility at 11:45 a.m. on 05/15/14, the</p>	K010160	<p><b><u>Corrective Action:</u></b> A shunt trip for the East Elevator equipment room has been ordered and will be installed by June 14, 2014.</p> <p><b><u>How Others</u></b></p> <p><b><u>Identified/Corrective Action:</u></b> A shunt trip for the main elevator machine room on the roof has been ordered and will be installed by June 14, 2014. <b><u>Preventative Measures Put in Place:</u></b> An in-service will be conducted with the maintenance department on the regulation, policy and procedure for the Elevator Equipment and machine rooms and testing and maintenance of the shunt trip. This elevator equipment and machine rooms will be put on a monthly preventative maintenance checklist. <b><u>Monitoring and QI:</u></b> The elevator equipment and machine rooms will be put on a monthly preventative maintenance checklist. The Preventative Maintenance List will be reviewed monthly with the Director of Environmental Services in QI and the summary</p>	06/14/2014

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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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K020000	<p>basement elevator equipment area was provided with a sprinkler. Based on interview at the time of observation, maintenance staff # 1 and # 2 were not aware if a shunt trip for the elevator equipment area was provided.</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: 05/14/14 and 05/15/14</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 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</p>	K020000	<p>will be presented in the quarterly QA meeting.</p> <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 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 of violation existed.</p>	

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	<p>Safety Code (LSC) and 410 IAC 16.2. The 2012 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 (222) construction and was fully sprinklered with the exception of the areas cited at K56. 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 113 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 134 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered with the exception of the areas cited at K56. All areas providing facility services were sprinklered with the exception of the areas cited at K56.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system components and devices such as smoke detectors, horn/strobe devices, door holder devices, and fire alarm control equipment was complete. NFPA 72, National Fire Alarm Code, 7-3.2 requires fire alarm system devices such as smoke detectors, fire alarm boxes, horn/strobe devices, door holder devices, and fire alarm control equipment be tested annually. NFPA 72, 7-5.1 says paper or electronic media shall be permitted. Then in 7-5.2.1 it says records shall be retained until the next test and for 1 year thereafter. 7-5.2.2 says a permanent record of all inspections, testing, and maintenance shall be provided. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p>	K020052	<p><b>Corrective Action:</b> An annual inspection and testing of the fire alarm system, which included all devices, was conducted and completed on May 22, 2014. The written Fire Alarm inspection and Testing Report, which includes a detailed listing of individual devices tested, and sensitivity testing of smoke detectors will be retained as a permanent record.</p> <p><b>How Others Identified/Corrective Action:</b> The annual inspection and testing report was reviewed by the current Director of Environmental Services and the Administrator to verify the completeness of the report. <b>Preventative Measures Put in Place:</b> An inspection and testing of the fire alarm system shall be scheduled and completed on an annual basis. An in-service will be conducted for the maintenance department on the requirements for the annual inspection and necessary documentation. <b>Monitoring and QI:</b> The annual inspection and testing of the fire alarm system shall be reviewed in QA meeting</p>	06/14/2014	

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K020144 SS=F	<p>Based on review of the 08/09/13 Fire Alarm Inspection and Testing Report with the Chief Financial Officer (CFO) on 05/14/14 at 2:00 p.m., the following was noted:</p> <p>a. The 08/09/13 fire alarm system inspection which was marked as an "Annual" inspection indicated only 8 of 26 pull stations and 18 of 125 photo detectors were tested.</p> <p>b. The 08/09/13 fire alarm inspection lacked an itemized list of alarm initiating and supervisory devices with locations and individual test results.</p> <p>c. The smoke detectors in the Alarm Initiating Devices and Circuit Information section of the 06/26/12 Fire Alarm Inspection and Testing Report were listed as "Photo Detectors" and the same smoke detectors on the attached Alarm Inspection Points List were listed as "Ion" detectors.</p> <p>d. The Alarm Inspection Points List attached to the 06/26/12 Fire Alarm Inspection and Testing Report documents the "sensitivity" for the smoke detectors as 1.7 and the "Alarm" as 1.6 These issues were acknowledged by the CFO at the time of record review.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		on an annual basis.	

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	<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>1. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, Health Care Facilities, Chapter 3-4.4.1.1 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>Chapter 6-4.2.2 of NFPA 110, requires diesel-powered EPS installations that do not meet the requirements of Chapter 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</p>	K020144	<p><b>Corrective Action:</b> A 2 hour generator load test is scheduled to be conducted on June 2, 2014. The written results will be documented and available for inspection. A battery powered emergency light has been installed to provide emergency task lighting in and around the Caterpillar generator. <b>How Others Identified/Corrective Action:</b> This generator services the entire building and will be maintained properly per regulations. <b>Preventative Measures Put in Place:</b> An in-service will be conducted with the maintenance department on the regulation, policy and procedure for generator inspection, testing, and documentation requirements. The battery powered emergency lighting has been included on the list of emergency lighting and was tested May 29, 2014 on the 30 day – 30 second emergency lighting function test. <b>Monitoring and QI:</b> The documentation forms for the monthly testing of the generator, and emergency lighting will be reviewed by the Director of Environmental Services monthly in QI and reviewed quarterly in the QA meeting.</p>	06/14/2014

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	<p>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.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator - Monthly Test Log with the Chief Financial Officer (CFO) on 05/14/14 at 2:30 p.m., the following was noted:</p> <p>a. The monthly load information for January, February, March, and April was not documented. Additionally, the monthly load test log for January, 2014 through May, 2014 lacked the generator's name plate rating; what 30 % of the generator name plate rating is; the normal operating temperature and the transfer time.</p> <p>b. Documentation of generator load testing was not available for review for the time period of June, 2013 through December, 2013.</p> <p>c. The most recent load bank test occurred two years ago on 05/08/12.</p> <p>Based on interview at the time of record review, the CFO acknowledged the aforementioned issues regarding the generator.</p>				

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the Caterpillar generator set was enclosed within a fenced in area and was not provided with a battery powered emergency light for task lighting. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged battery powered emergency task lighting was not</p>			

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K030000	<p>provided.</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: 05/14/14 and 05/15/14</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 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>	K030000	<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 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 of violation existed.</p>				

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K030018 SS=E	<p>This two story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered with the exception of the areas cited at K56. 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 113 of 122 resident sleeping rooms. The facility has a capacity of 143 with a census of 134 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered with the exception of the areas cited at K56. All areas providing facility services were sprinklered with the exception of the areas cited at K56.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6</p>			

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K030052 SS=F	<p>are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 corridor doors for the main dining room closed and latched into the door frame. This deficient practice could affect at least 25 residents in the main dining room as well as an undetermined number of staff.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the two sets of double doors into the main dining room closed but did not latch into the frame. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged the latching devices for the main dining room doors were not functioning properly.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program</p>	K030018	<p><b>Corrective Action:</b> The 2 sets of double doors into the main dining room have been repaired to close and latch into the frames. <b>How Others Identified/Corrective Action:</b> The Director of Environmental Services will conduct an audit of all corridor doors to ensure they latch into the door frame and repairs will be made to any doors found to not latch into the door frame. This audit includes the Main Dining Room Doors. The results of this audit will be documented on an audit form. <b>Preventative Measures Put in Place:</b> The existing Door Latch Audit form will be updated to include all corridor doors and will also include the Main Dining Room doors. An In-Service will be conducted for all staff on education of Fire Safety and the necessity for doors to latch into the door frame. <b>Monitoring and QI:</b> The Door Latch Audit will be conducted weekly for 3 months and monthly thereafter. Audits will be reviewed in QI monthly x 3 months and quarterly in the QA meeting thereafter.</p>	06/14/2014			

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	<p>complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system components and devices such as smoke detectors, horn/strobe devices, door holder devices, and fire alarm control equipment was complete. NFPA 72, National Fire Alarm Code, 7-3.2 requires fire alarm system devices such as smoke detectors, fire alarm boxes, horn/strobe devices, door holder devices, and fire alarm control equipment be tested annually. NFPA 72, 7-5.1 says paper or electronic media shall be permitted. Then in 7-5.2.1 it says records shall be retained until the next test and for 1 year thereafter. 7-5.2.2 says a permanent record of all inspections, testing, and maintenance shall be provided. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the 08/09/13 Fire Alarm Inspection and Testing Report with the Chief Financial Officer (CFO) on 05/14/14 at 2:00 p.m., the following was noted:</p> <p>a. The 08/09/13 fire alarm system inspection which was marked as an</p>	K030052	<p><b>Corrective Action:</b> An annual inspection and testing of the fire alarm system, which included all devices, was conducted and completed on May 22, 2014. The written Fire Alarm inspection and Testing Report, which includes a detailed listing of individual devices tested, and sensitivity testing of smoke detectors will be retained as a permanent record.</p> <p><b>How Others Identified/Corrective Action:</b> The annual inspection and testing report was reviewed by the current Director of Environmental Services and the Administrator to verify the completeness of the report. <b>Preventative Measures Put in Place:</b> An inspection and testing of the fire alarm system shall be scheduled and completed on an annual basis. An in-service will be conducted for the maintenance department on the requirements for the annual inspection and necessary documentation. <b>Monitoring and QI:</b> The annual inspection and testing of the fire alarm system shall be reviewed in QA meeting on an annual basis.</p>	06/14/2014

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K030144 SS=F	<p>"Annual" inspection indicated only 8 of 26 pull stations and 18 of 125 photo detectors were tested.</p> <p>b. The 08/09/13 fire alarm inspection lacked an itemized list of alarm initiating and supervisory devices with locations and individual test results.</p> <p>c. The smoke detectors in the Alarm Initiating Devices and Circuit Information section of the 06/26/12 Fire Alarm Inspection and Testing Report were listed as "Photo Detectors" and the same smoke detectors on the attached Alarm Inspection Points List were listed as "Ion" detectors.</p> <p>d. The Alarm Inspection Points List attached to the 06/26/12 Fire Alarm Inspection and Testing Report documents the "sensitivity" for the smoke detectors as 1.7 and the "Alarm" as 1.6</p> <p>These issues were acknowledged by the CFO at the time of record review.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the</p>	K030144	<b>Corrective Action:</b> A 2 hour generator load test is scheduled to be conducted on June 2, 2014. The written results will be	06/14/2014

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  05/15/2014
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>requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, Health Care Facilities, Chapter 3-4.4.1.1 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>Chapter 6-4.2.2 of NFPA 110, requires diesel powered EPS installations that do not meet the requirements of Chapter 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.</p> <p>This deficient practice could affect all</p>		<p>documented and available for inspection. A battery powered emergency light has been installed to provide emergency task lighting in and around the Caterpillar generator. <b>How Others Identified/Corrective Action:</b> This generator services the entire building and will be maintained properly per regulations. <b>Preventative Measures Put in Place:</b> An in-service will be conducted with the maintenance department on the regulation, policy and procedure for generator inspection, testing, and documentation requirements. The battery powered emergency lighting has been included on the list of emergency lighting and was tested May 29, 2014 on the 30 day – 30 second emergency lighting function test. <b>Monitoring and QI:</b> The documentation forms for the monthly testing of the generator, and emergency lighting will be reviewed by the Director of Environmental Services monthly in QI and reviewed quarterly in the QA meeting.</p>		

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator - Monthly Test Log with the Chief Financial Officer (CFO) on 05/14/14 at 2:30 p.m., the following was noted:</p> <p>a. The monthly load information for January, February, March, and April was not documented. Additionally, the monthly load test log for January, 2014 through May, 2014 lacked the generator's name plate rating; what 30 % of the generator name plate rating is; the normal operating temperature and the transfer time.</p> <p>b. Documentation of generator load testing was not available for review for the time period of June, 2013 through December, 2013.</p> <p>c. The most recent load bank test occurred two years ago on 05/08/12. Based on interview at the time of review, the CFO acknowledged the aforementioned issues regarding the generator.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the</p>						

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	<p>generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with maintenance staff # 1 and maintenance staff # 2 on 05/15/14 from 10:00 a.m. to 12:15 p.m., the Caterpillar generator set was enclosed within a fenced in area and was not provided with a battery powered emergency light for task lighting. Based on interview at the time of observation, maintenance staff # 1 and maintenance staff # 2 acknowledged battery powered emergency task lighting was not provided.</p> <p>3.1-19(b)</p>			