STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155153		06/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHWIN	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	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). Survey Dates: 06/22/15 and 06/23/15 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 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. 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	K 0000	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 or violation existed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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. 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.			
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 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 outside wall. This deficient practice was not in a resident care area but could affect facility staff.	K 0025	**Corrective Action:** The one inch penetration in the ceiling of the in the oxygen trans-filling room has been 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	07/22/2015

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	Findings include: Based on an observation on 6/23/15 at 10:25 a.m. with the Maintenance Supervisor, Administrator, and Chief Financial Officer, there was a one inch penetration in the ceiling in the oxygen transfilling room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and gave the measurement. 3.1-19(b)		ascertain that smoke barriers are maintained. **Preventive Measures Put in Place:** An In-Service will be conducted for our 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 documented and presented to the QI Committee on a quarterly basis.	
K 0038 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress for 1 of 2 exits for the Northwest smoke compartment was arranged so that exits were readily accessible at all times. This deficient practice could affect 9 residents, staff, and visitors. Findings include: Based on observation with the Maintenance Supervisor and	K 0038	**Corrective Action:** The four chairs and table that were temporarily stored in the corridor, due to the use of the Beauty Shop, were removed. **How Others Identified/Corrective Action:** No other areas were identified that required the removal of furniture that obstructed corridors and or exits. **Preventive Measures Put in Place:** The Beauticians have been instructed concerning the necessity for not obstructing corridors and exits. Chairs and	06/29/2015

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	Administration on 06/22/15 at 2:04 p.m., four chairs and one table used for the Beauty Salon were stored in the corridor. Based on interview at the time of observation, the Maintenance Supervisor said the Beauty Salon uses and stores the chairs in the corridor. The Maintenance Supervisor and Administrator acknowledged the aforementioned condition. 3.1-19(b)		tables will no longer be temporarily stored in the corridor. **Monitoring and QI:** The Chief Financial Officer and Maintenance Supervisor will continue to monitor said area and report any issues to the QI Committee on a quarterly basis.	
K 0046 SS=E Bldg. 01	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. Based on observation, record review and interview; the facility failed to ensure 4 of 4 emergency light fixtures were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 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 all occupants.	K 0046	**Corrective Action:** An annual 90 minute test of battery operated emergency lighting has been conducted and documented on the Battery Operated Emergency Light Test Log. **How Others Identified/Corrective Action:** An annual 90 minute test of battery operated emergency lighting has been conducted and documented on the Battery Operated Emergency Light Test Log. **Preventive Measures Put in Place:** The required 90 minute testing will be scheduled and completed on an annual basis. An in-service will be conducted for the Maintenance Department on pertaining to the requirement of the annual 90 minute test. **Monitoring and QI:** The Battery	07/22/2015

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	Findings include: Based on observations with Maintenance Supervisor and Administrator on 06/22/15 at 11:21 a.m., four battery operated emergency lights were observed in the facility's stairwells. Based on interview at record review with Maintenance Supervisor and Administrator, the battery operated emergency lights test log only included monthly testing. The Maintenance Supervisor said he did not know a 90 minute annual test was required and acknowledge the aforementioned deficiency. 3.1-19(b)		Operated Emergency Light Test Log will be presented to the QI Committee on a quarterly basis.	
K 0048 SS=E Bldg. 01	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 provide a written plan that included the different types and the use of fire extinguishers provided in the facility 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: (1) Use of alarms	K 0048	**Corrective Action:** The Disaster Plan & Procedure - Fire Plan has been updated to include language pertaining to the evacuation of a smoke compartment, preparation of floors and buildings in evacuation, and the extinguishment of fire requirement to include K-class fire extinguisher in relationship with the use of the kitchen hood	07/22/2015

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	(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 This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor and Administrator on 06/23/15 at 12:22 p.m., the "Fire Plan - Safety" did not address (5) Evacuation of a smoke compartment nor (7) Preparation of floors and building for evacuation. (8) Extinguishment of fire requirement failed to include the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Maintenance Supervisor and Administrator at the time of record review. 3.1-19(b)		extinguishing system. **How Others Identified/Corrective Action:** The Disaster Plan & Procedure - Fire Plan has been updated. **Preventive Measures Put in Place:** An in-service will be conducted for all staff pertaining to the evacuation of a smoke compartment, preparation of floors and buildings in evacuation, and the extinguishment of fire requirement to include K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. **Monitoring and QI:** The Disaster Plan and Procedures will be reviewed annually and updated as necessary and presented to the QI Committee on a quarterly basis.	
K 0050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			
	Based on record review and interview, the facility failed to conduct 2nd shift quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Drill Documentation" forms with the Administrator and the Maintenance Supervisor on 06/22/15 at 11:32 a.m., all second shift fire drills took place between 2:45 p.m. and 4:00 p.m. for four of the last four quarters. Based on interview at the time of record review, the Administrator and Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0050	**Corrective Action:** A fire drill will be conducted on 7/18/15 at 7:00 PM. **How Others Identified/Corrective Action:** Future fire drills have been scheduled at unexpected times and days taking into consideration a rolling twelve month period of time. **Preventive Measures Put in Place:** A fire drill schedule has been prepared, which will schedule fire drills at unexpected times and dates, on a going forward basis, taking into consideration a rolling twelve month period of time. **Monitoring and QI:** The timing of actual fire drills and scheduled fire drills will be monitored by the Chief Financial Officer, on a monthly basis, to assure that fire drills are conducted at unexpected times. The results of this monitoring will be reported to the QI Committee on a quarterly basis.	07/18/2015
K 0052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	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, observation, and interview; the facility failed to ensure there was documentation for the testing of 113 of 113 resident room smoke detectors. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of "Battery Operated Smoke Detector Maintenance Log for 2015" on 06/22/15 at 12:35 p.m. with the Maintenance Supervisor and Administrator, the log did not include a date for battery replacement. Based on interview, the Maintenance Supervisor said they replace the smoke alarm batteries when they chirp. The Maintenance Supervisor and Administrator acknowledged the aforementioned condition. 3-1.19(b)	K 0052	**Corrective Action:** All resident room smoke detector batteries have been replaced with new batteries and documented on the Battery Operated Smoke Detector Maintenance Log. **How Others Identified/Corrective Action:** All resident room smoke detector batteries have been replaced with new batteries. **Preventive Measures Put in Place:** All resident room smoke detector batteries will be replaced annually,with the replacement date documented on the Battery Operated Smoke Detector Maintenance Log. **Monitoring and QI:** The Battery Operated Smoke Detector Log will be presented to the QI Committee on a quarterly basis.	07/22/2015

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K 0056 SS=E Bldg. 01	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 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 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 2 of 2 stairwells. NFPA 13, 5-13.3.2 states in noncombustible stair shafts with 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 east and west stairwells. Findings include:	K 0056	**Corrective Action:** While we believe that 2 of the 2 the stairwells referred to do meet NFPA 13, 5-13.3.2 as the stair shafts and stairs are non-combustible and sprinklers are installed at the top of the shaft and under the first landing above the bottom of the shaft, the additional requested sprinklers will be installed. **How Others Identified/Corrective Action:** No additional corrective actions were identified. **Preventive Measures Put in Place:** Ongoing construction projects that require sprinkling are reviewed and approved prior to receiving authorization to construct and occupy. **Monitoring and QI:** The Sprinkling system will be inspected quarterly and annually	07/22/2015

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	Based on observation with the Maintenance Supervisor and Administrator on 06/23/15 at 12:29 p.m. then again at 1:29 p.m., the top of the two story west stairwell was sprinklered, the bottom of the stairwell was sprinklered, but not the landing for first floor including the stairs covered by the second story stairs. The two story east stairwell was discovered to lack similar sprinkler coverage. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the lack of sprinkler coverage between the second story and the basement. 3.1-19(b)		by a certified contractor. The Inspection reports will be presented to the QI Committee on a quarterly basis.	
K 0062 SS=D Bldg. 01	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 1. Based on observation and interview the facility failed to maintain 3 of 3 fire hoses. NFPA 25 3-2.3 Table 3-2.3 shall be used for the inspection, testing, and maintenance of all classes of standpipe and hose systems. Hoses need to be inspected per NFPA 1963 Standard for the Care, Use, and Service Testing of Fire	K 0062	**Corrective Action:** The fire hoses and handles have been removed. The overhead light in the Basement Medical Records Storage Area, has been adjusted, so as to not apply pressure on the support to the sprinkler line. **How Others Identified/Corrective Action:** No additional instances of pressure being applied to sprinkler supports were identified.	07/22/2015

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	Hose Including Couplings and Nozzles. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observation on 6/22/15 at 1:48 p.m. with the Maintenance Supervisor and Administrator, a fire hose was discovered protected in a glass cabinet. Based on interview, when the fire hose was acknowledged, the Administrator said they were planning training based on the fire hoses. The Maintenance Supervisor and Administrator could not provide documentation for maintenance and testing of the fire hoses. 3.1-19(b) 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. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice was not in a patient treatment area but could affect any staff in the basement. Findings include: Based on observations with the		**Preventive Measures Put in Place:** An In-Service will be conducted for our Maintenance Department pertaining to Fire Safety and the necessity for maintaining sprinkler lines and supports and maintenance of existing equipment. **Monitoring and QI:** Any issues discovered pertaining to the maintenance of sprinkler lines and supports will be reported to the QI Committee on a quarterly basis.	

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	Maintenance Supervisor and Administrator on 06/22/15 at 4:17 p.m., in the Basement Medical Storage Room there was an overhead light chained above the sprinkler line applying horizontal pressure and partial support to the sprinkler line. Based on interview at the time of observation, Maintenance Supervisor and Administrator acknowledged the aforementioned condition. 3.1-19(b)			
K 0064 SS=D Bldg. 01	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 ensure 1 of 1 Dining Room Alcove and 1 of 1 Therapy Hallway fire extinguisher pressure gauge readings was in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure	K 0064	**Corrective Action:** The fire extinguisher that was discovered to be undercharged and the fire extinguisher that appeared to be over charged have been replaced. **How Others Identified/Corrective Action:** Based upon review of all other fire extinguishers, all appeared to be adequately charged. **Preventive Measures Put in Place:** An In-Service will be conducted for our Maintenance Department pertaining to Fire Safety and the necessity for maintaining fire extinguishers. All fire extinguishers will be checked	07/22/2015

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	the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could all residents, staff, and visitors in the dining room and 8 residents near Therapy Hallway. Findings include: Based on observation with the Maintenance Supervisor and Administrator on 6/22/15 at 2:20 p.m. then again on 6/23/15 10:14 a.m. with the Maintenance Supervisor, Administrator, and Chief Financial Officer, the Dining Room Alcove fire extinguisher needle was discovered in the undercharged range. Then again the Therapy Hallway fire extinguisher needle was in the overcharged range. Based on interview at the time of each observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition. 3.1-19(b)		on a monthly basis to assure adequate charging. The results of the monthly monitoring will be documented. **Monitoring and QI:** Monthly documentation will be presented to the QI Committee on a quarterly basis.	
K 0070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD			

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(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
Bldg. 01	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and record review, the facility failed to enforce the policy for the use of 2 of 2 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff. Findings include: Based on an observation with the Maintenance Supervisor and Administrator on 6/22/15 at 1:37 p.m. then again at 3:18 p.m., a space heater was discovered in the Managers Business Office then again in the Staff Development Office. Based on record review with the Maintenance Supervisor and Administrator, they acknowledged that space heaters were a violation of the facility's policy. 3.1-19(b)	K 0070	**Corrective Action:** Healthwin's policy has been modified to allow the use of portable heaters in non-sleeping staff areas and employee areas where heating elements do not exceed 212 degrees F. **How Others Identified/Corrective Action:** Portable heaters in non-sleeping staff areas and employee areas have been inspected and are in compliance with our reviewed policy. **Preventive Measures Put in Place:** An In-Service will be conducted for all staff pertaining to Fire Safety and our newly revised portable heater policy. **Monitoring and QI:** Portable heaters will be inspected for approval by the Maintenance Department to ensure compliance with established policies.	07/22/2015
K 0072 SS=E Bldg. 01	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,			

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	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 all obstructions or impediments to full instant use for 1 of 1 exterior exit in the Northwest smoke compartment. This deficient practice could affect approximately 9 residents, staff, and visitors. Findings include: Based on observation on 06/22/15 at 2:01 p.m. with the Maintenance Supervisor and Administrator, the egress path from the Northwest exit was blocked. The path to the left was blocked by the raised porch for West 1 egress discharge, the path straight ahead led to the waterfall and pond, the path to the right was fenced off and was a drop off for the new construction. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition. 3.1-19(b)	K 0072	**Corrective Action:** An additional sidewalk will be installed to assure that the means of egress is continuously maintained free of obstructions or impediments. **How Others Identified/Corrective Action:** Based upon review of all other means of egress, none were obstructed. **Preventive Measures Put in Place:** Ongoing construction projects that require modifications to established means of egress, will be addressed prior to the start of construction. **Monitoring and QI:** Any construction projects that require modifications to established means of egress, will be addressed prior to the start of construction and presented to the QI Committee on a quarterly basis.	07/22/2015
K 0130 SS=D	NFPA 101 MISCELLANEOUS			

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Bldg. 01	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 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: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (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: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved	K 0130	**Corrective Action:** The penetration in the fire wall near resident room 201 has been sealed and patched. **How Others Identified/Corrective Action:** Areas affected by renovations/repairs will be reviewed by the Maintenance Supervisor to ascertain that fire barriers are maintained. **Preventive Measures Put in Place:** An In-Service will be conducted for our Maintenance Department on education of Fire Safety and the necessity for maintaining fire 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 fire barriers are maintained. Inspection results will be documented and presented to the QI Committee on a quarterly basis.	07/22/2015

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	device that is designed for the specific purpose. This deficient practice could affect residents in 2 of 8 smoke compartments. Findings include: Based on an observation with the Maintenance Supervisor, Administrator, and Chief Financial Officer on 06/23/15 at 10:31 a.m., above the drop ceiling is a one inch penetration in the fire wall near resident room 201. The Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)			
K 0144 SS=C Bldg. 01	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. Based on record review and interview, the facility failed to ensure maintenance and testing on 1 of 2 generators per Chapter 3-4.2.2.2 of NFPA 99 Maintenance and Testing of Essential Electrical Systems and NFPA 110 Chapter 6 Routine Maintenance and Operational Testing. This deficient practice could affect a few outlets that it could be required to power.	K 0144	**Corrective Action:** The additional back-up generator has been disconnected and will not be used as the main generator meets all requirements for the building. **How Others Identified/Corrective Action:** There are no other back-up generators connected to the building. **Preventive Measures Put in Place:** Any generator that is installed for the building in the future will be inspected weekly	07/02/2015

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	Findings include: Based on record review of the "Emergency Generator - Monthly Test Log" with the Maintenance Supervisor and Administrator on 06/22/15 and 06/23/15 at 11:18 a.m., the record review of the "Emergency Generator - Monthly Test Log" showed all proper inspection and testing of the facility's primary generator. Based on interview during record review, the Maintenance Supervisor said the facility does have a backup generator that would have to be manually switched over if their primary generator lost power. He continued in saying that because the size of the generator, it is only set up to power a few outlets in the facility. No documentation for inspection and testing was available for the backup generator. The Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		and exercised under load for 30 minutes per month in accordance with NFPA 99. **Monitoring and QI:** Any generator that is installed for the building in the future will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. The Generator inspections and load tests for the required generator are reviewed quarterly in the QI Committee.	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the	K 0147	**Corrective Action:** All noted extension cords and power strips	07/22/2015

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	facility failed to ensure 9 of 9 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 5 residents at the nurse's station. Findings include: Based on observation with Maintenance Supervisor and Administrator on 06/22/15 between 1:34 p.m. and 3:55 p.m. the following was discovered: a. Extension cord powering a microwave and refrigerator in the Business Office b. Powerstrip powering two chair hair dryers in the Beauty Salon c. Extension cord in payroll d. Power strip powering air conditioner in HR Assistance office e. Extension cord powering a radio in the Boiler Room office. f. Extension cord to moveable light in the Basement Circulating Pump room. g. Extension cord powering two cell phones. Surge protector powering a microwave in the Basement Housekeeping Based on interview at the time of each		have been removed. **How Others Identified/Corrective Action:** Based upon review, no additional inappropriately used extension cord or power strips needed to be removed. **Preventive Measures Put in Place:** An in-service for all staff will be conducted pertaining to the use of extension cords and power strips. **Monitoring and QI:** An extension cord/power strip audit will be conducted on a monthly basis. Audits will be presented to the QI Committee on a quarterly basis.	

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	observation with the Maintenance Supervisor and Administrator acknowledged each aforementioned condition. Based on observation with Maintenance Supervisor, Administrator, and Chief Financial Officer on 06/23/15 at 9:14 a.m., a multiplug adapter powering a television and radio in Resident Room 285. Based on interview at the time of each observation with the Maintenance Supervisor, Administrator, and Chief Financial Officer acknowledged the aforementioned condition. 3.1-19(b)			
K 0000 Bldg. 02	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). Survey Dates: 06/22/15 and 06/23/15 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820	K 0000	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	

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	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 Chapter 18, New Health Care Occupancies. 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. 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.		should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law. The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.	

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K 0018 SS=D Bldg. 02	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 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 1 of 21 West 1 resident room doors latched into the door frame. This deficient practice could affect 30 residents and staff. Findings include: Based on observations on 6/22/15 at 1:02 p.m., with the Maintenance Supervisor and Administrator, resident room 148 failed to latch when tested. Based on interview at the time of observation, the Maintenance Supervisor an Administrator acknowledged the aforementioned condition. 3.1-19(b)	K 0018	**Corrective Action:** The door latch to resident room 148 has been fixed, so that it latches into the door frame. **How Others Identified/Corrective Action:** An audit of all corridor doors will be conducted to ensure doors latch into the door frames. Repairs and adjustments will be made as needed. The results of this audit will be documented on the audit form. **Preventive Measures Put in Place:** An audit of all corridor doors will be conducted, on a monthly basis, to ensure doors latch into the door frames. Repairs and adjustments will be made as needed. The results of this audit will be documented on the audit form. An in-service will be conducted for all staff pertaining to the necessity for doors to latch into the door frame. **Monitoring and QI:** The Door Latch Audit will be conducted on a monthly basis. Audits will be reviewed at the quarterly QI meetings.	07/22/2015
K 0022 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily			

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	apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit from the West 1 Family Room was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect 30 residents in the smoke compartment. Findings include: Based on observation with the Maintenance Supervisor and Administrator on 06/22/15 at 1:11 p.m., the door leading to the outside of the West 1 Family Room lacked a sign that identified the door either as an exit or not an exit. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the door could be confused for an exit. 3.1-19(b)	K 0022	**Corrective Action:** A sign indicating "This Is Not An Exit" has been installed on the West 1 Family Room door. **How Others Identified/Corrective Action:** Based upon review, no additional doors were identified that required a sign indicating "This Is Not n Exit". **Preventive Measures Put in Place:** Construction/renovation projects that require modifications to established means of egress, will be addressed prior to the start of construction and addressed on a quarterly basis at the QI Committee. **Monitoring and QI**: Construction/renovation projects that require modifications to established means of egress, will be addressed prior to the start of construction and addressed on a quarterly basis at QI meetings.	06/25/2015
K 0046 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.			

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	18.2.9.1 Based on observation, record review and interview; the facility failed to ensure 4 of 4 emergency light fixtures were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 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 all occupants. Findings include: Based on observations with Maintenance Supervisor and Administrator on 06/22/15 at 11:21 a.m., four battery operated emergency lights were observed in the facility's stairwells. Based on interview at record review with Maintenance Supervisor and Administrator, the battery operated emergency lights test log only included monthly testing. The Maintenance Supervisor said he did not know a 90 minute annual test was required and acknowledge the aforementioned deficiency.	K 0046	**Corrective Action:** An annual 90 minute test of battery operated emergency lighting has been conducted and documented on the Battery Operated Emergency Light Test Log. **How Others Identified/Corrective Action:** An annual 90 minute test of battery operated emergency lighting has been conducted and documented on the Battery Operated Emergency Light Test Log. **Preventive Measures Put in Place:** The required 90 minute testing will be scheduled and completed on an annual basis. An in-service will be conducted for the Maintenance Department on pertaining to the requirement of the annual 90 minute test. **Monitoring and QI:** The Battery Operated Emergency Light Test Log will be presented to the QI Committee on a quarterly basis.	07/22/2015

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	3.1-19(b)			
K 0048 SS=E Bldg. 02	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. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included details of evacuation of a smoke compartment; preparation of floors and the building for evacuation and the different types and uses of fire extinguishers provided in the facility 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: (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 This deficient practice could affect all occupants. Findings include:	K 0048	**Corrective Action:** The Disaster Plan & Procedure - Fire Plan has been updated to include language pertaining to the evacuation of a smoke compartment, preparation of floors and buildings in evacuation, and the extinguishment of fire requirement to include K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. **How Others Identified/Corrective Action:** The Disaster Plan & Procedure - Fire Plan has been updated. **Preventive Measures Put in Place:** An in-service will be conducted for all staff pertaining to the evacuation of a smoke compartment, preparation of floors and buildings in evacuation, and the extinguishment of fire requirement to include K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. **Monitoring and QI:** The Disaster Plan and Procedures will be reviewed annually and updated as necessary and presented to the	07/22/2015

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	Based on a record review with the Maintenance Supervisor and Administrator on 06/23/15 at 12:22 p.m., the "Fire Plan - Safety" did not address (6) Evacuation of a smoke compartment nor (7) Preparation of floors and building for evacuation. (8) Extinguishment of fire requirement failed to include the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was confirmed by the Maintenance Supervisor and Administrator at the time of record review. 3.1-19(b)		QI Committee on a quarterly basis.	
K 0050 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire	K 0050	**Corrective Action:** A fire drill will be conducted on 7/18/15 at 7:00	07/18/2015

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	drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Drill Documentation" forms with the Administrator and the Maintenance Supervisor on 06/22/15 at 11:32 a.m., all second shift fire drills took place between 2:45 p.m. and 4:00 p.m. for four of the last four quarters. Based on interview at the time of record review, the Administrator and Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		PM. **How Others Identified/Corrective Action:** Future fire drills have been scheduled at unexpected times and days taking into consideration a rolling twelve month period of time. **Preventive Measures Put in Place:** A fire drill schedule has been prepared, which will schedule fire drills at unexpected times and dates, on a going forward basis, taking into consideration a rolling twelve month period of time. **Monitoring and QI:** The timing of actual fire drills and scheduled fire drills will be monitored by the Chief Financial Officer, on a monthly basis, to assure that fire drills are conducted at unexpected times. The results of this monitoring will be reported to the QI Committee on a quarterly basis.	
K 0052 SS=E Bldg. 02	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, observation, and interview; the facility failed to ensure there was documentation for the testing of 113 of 113 resident room smoke detectors. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices	K 0052	**Corrective Action:** All resident room smoke detector batteries have been replaced with new batteries and documented on the Battery Operated Smoke Detector Maintenance Log. **How Others Identified/Corrective Action:** All resident room smoke detector	07/22/2015

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	155153		06/23/2015

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

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	such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of "Battery Operated Smoke Detector Maintenance Log for 2015" on 06/22/15 at 12:35 p.m. with the Maintenance Supervisor and Administrator, the log did not include a date for battery replacement. Based on interview, the Maintenance Supervisor said they replace the smoke alarm batterys when they chirp. The Maintenance Supervisor and Admisitrator acknowledged the aformentioned condition. 3-1.19(b)		batteries have been replaced with new batteries. **Preventive Measures Put in Place:** All resident room smoke detector batteries will be replaced annually,with the replacement date documented on the Battery Operated Smoke Detector Maintenance Log. **Monitoring and QI:** The Battery Operated Smoke Detector Log will be presented to the QI Committee on a quarterly basis.	
K 0056 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are			

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	connected to the fire alarm system. 18.3.5. 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 2 of 2 stairwells. NFPA 13, 5-13.3.2 states in noncombustible stair shafts with 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 east and west stairwells. Findings include: Based on observation with the Maintenance Supervisor and Administrator on 06/23/15 at 12:29 p.m. then again at 1:29 p.m., the top of the two story west stairwell was sprinklered, the bottom of the stairwell was sprinklered, but not the landing for first floor including the stairs covered by the second story stairs. The two story east stairwell was discovered to lack similar sprinkler coverage. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the lack of sprinkler	K 0056	**Corrective Action:** While we believe that 2 of the 2 the stairwells referred to do meet NFPA 13, 5-13.3.2 as the stair shafts and stairs are non-combustible and sprinklers are installed at the top of the shaft and under the first landing above the bottom of the shaft, the additional requested sprinklers will be installed. **How Others Identified/Corrective Action:** No additional corrective actions were identified. **Preventive Measures Put in Place:** Ongoing construction projects that require sprinkling are reviewed and approved prior to receiving authorization to construct and occupy. **Monitoring and QI:** The Sprinkling system will be inspected quarterly and annually by a certified contractor. The Inspection reports will be presented to the QI Committee on a quarterly basis.	07/22/2015

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	coverage between the second story and the basement. 3.1-19(b)			
K 0144 SS=C Bldg. 02	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. Based on record review and interview, the facility failed to ensure maintenance and testing on 1 of 2 generators per Chapter 3-4.2.2.2 of NFPA 99 Maintenance and Testing of Essential Electrical Systems and NFPA 110 Chapter 6 Routine Maintenance and Operational Testing. This deficient practice could affect a few outlets that it could be required to power. Findings include: Based on record review of the "Emergency Generator - Monthly Test Log" with the Maintenance Supervisor and Administrator on 06/22/15 and 06/23/15 at 11:18 a.m., the record review of the "Emergency Generator - Monthly Test Log" showed all proper inspection and testing of the facility's primary generator. Based on interview during record review, the Maintenance	K 0144	**Corrective Action:** The additional back-up generator has been disconnected and will not be used as the main generator meets all requirements for the building. **How Others Identified/Corrective Action:** There are no other back-up generators connected to the building. **Preventive Measures Put in Place:** Any generator that is installed for the building in the future will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. **Monitoring and QI:** Any generator that is installed for the building in the future will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. The Generator inspections and load tests for the required generator are reviewed quarterly in the QI Committee.	07/02/2015

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	Supervisor said the facility does have a backup generator that would have to be manually switched over if their primary generator lost power. He continued in saying that because the size of the generator, it is only set up to power a few outlets in the facility. No documentation for inspection and testing was available for the backup generator. The Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)			
K 0000 Bldg. 03	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). Survey Dates: 06/22/15 and 06/23/15 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 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	K 0000	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	

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	Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2012 addition was surveyed with Chapter 18, New Health Care Occupancies. 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. 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.		alleged deficiency or violation existed.	
K 0048 SS=E Bldg. 03	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. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included details of evacuation of	K 0048	**Corrective Action:** The Disaster Plan & Procedure - Fire Plan has been updated to include language pertaining to the evacuation of a	07/22/2015

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	a smoke compartment; preparation of floors and the building for evacuation and the different types and uses of fire extinguishers provided in the facility 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: (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 This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor and Administrator on 06/23/15 at 12:22 p.m., the "Fire Plan - Safety" did not address (6) Evacuation of a smoke compartment nor (7) Preparation of floors and building for evacuation. (8) Extinguishment of fire requirement failed to include the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. This was		smoke compartment, preparation of floors and buildings in evacuation, and the extinguishment of fire requirement to include K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. **How Others Identified/Corrective Action:** The Disaster Plan & Procedure - Fire Plan has been updated. **Preventive Measures Put in Place:** An in-service will be conducted for all staff pertaining to the evacuation of a smoke compartment, preparation of floors and buildings in evacuation, and the extinguishment of fire requirement to include K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. **Monitoring and QI:** The Disaster Plan and Procedures will be reviewed annually and updated as necessary and presented to the QI Committee on a quarterly basis.	

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	confirmed by the Maintenance Supervisor and Administrator at the time of record review. 3.1-19(b)			
K 0050 SS=C Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to conduct 2nd shift quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on record review of the "Fire Drill Documentation" forms with the Administrator and the Maintenance Supervisor on 06/22/15 at 11:32 a.m., all second shift fire drills took place between 2:45 p.m. and 4:00 p.m. for four of the last four quarters. Based on interview at the time of record review, the Administrator and Maintenance	K 0050	**Corrective Action:** A fire drill will be conducted on 7/18/15 at 7:00 PM. **How Others Identified/Corrective Action:** Future fire drills have been scheduled at unexpected times and days taking into consideration a rolling twelve month period of time. **Preventive Measures Put in Place:** A fire drill schedule has been prepared, which will schedule fire drills at unexpected times and dates, on a going forward basis, taking into consideration a rolling twelve month period of time. **Monitoring and QI:** The timing of actual fire drills and scheduled fire drills will be monitored by the Chief Financial Officer, on a monthly basis, to assure that fire drills are conducted at unexpected times.	07/18/2015

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	Supervisor acknowledged the aforementioned condition. 3.1-19(b)		The results of this monitoring will be reported to the QI Committee on a quarterly basis.	
K 0052 SS=E Bldg. 03	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, observation, and interview; the facility failed to ensure there was documentation for the testing of 113 of 113 resident room smoke detectors. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of "Battery Operated Smoke Detector Maintenance Log for 2015" on 06/22/15 at 12:35 p.m. with the Maintenance Supervisor and Administrator, the log did not include a date for battery replacement. Based on interview, the Maintenance Supervisor	K 0052	**Corrective Action:** All resident room smoke detector batteries have been replaced with new batteries and documented on the Battery Operated Smoke Detector Maintenance Log. **How Others Identified/Corrective Action:** All resident room smoke detector batteries have been replaced with new batteries. **Preventive Measures Put in Place:** All resident room smoke detector batteries will be replaced annually,with the replacement date documented on the Battery Operated Smoke Detector Maintenance Log. **Monitoring and QI:** The Battery Operated Smoke Detector Log will be presented to the QI Committee on a quarterly basis.	07/22/2015

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	said they replace the smoke alarm batterys when they chirp. The Maintenance Supervisor and Admisitrator acknowledged the aformentioned condition. 3-1.19(b)			
K 0144 SS=C Bldg. 03	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. Based on record review and interview, the facility failed to ensure maintenance and testing on 1 of 2 generators per Chapter 3-4.2.2.2 of NFPA 99 Maintenance and Testing of Essential Electrical Systems and NFPA 110 Chapter 6 Routine Maintenance and Operational Testing. This deficient practice could affect a few outlets that it could be required to power. Findings include: Based on record review of the "Emergency Generator - Monthly Test Log" with the Maintenance Supervisor and Administrator on 06/22/15 and 06/23/15 at 11:18 a.m., the record review of the "Emergency Generator - Monthly Test Log" showed all proper inspection and testing of the facility's primary	K 0144	**Corrective Action:** The additional back-up generator has been disconnected and will not be used as the main generator meets all requirements for the building. **How Others Identified/Corrective Action:** There are no other back-up generators connected to the building. **Preventive Measures Put in Place:** Any generator that is installed for the building in the future will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. **Monitoring and QI:** Any generator that is installed for the building in the future will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. The Generator inspections and load tests for the required generator are reviewed quarterly in the QI Committee.	07/02/2015

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	generator. Based on interview during record review, the Maintenance Supervisor said the facility does have a backup generator that would have to be manually switched over if their primary generator lost power. He continued in saying that because the size of the generator, it is only set up to power a few outlets in the facility. No documentation for inspection and testing was available for the backup generator. The Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)			