STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING 04 / B. WING	03/07/2016

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. 04	An Initial Life Safety Code Certification and State Licensure Survey for a two story addition with therapy space on the 1st floor and 10 resident rooms on the 2nd floor was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/07/16 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Life Safety Code Preoccupancy survey, the Healthwin addition was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. This two story addition was determined to be of Type II (111) construction and was fully sprinklered with the exception of the areas cited at K56. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	X3) DATE SURVEY COMPLETED
	155153		03/07/2016

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
	corridors. The facility has a total capacity of 143 with a census of 0 in the addition 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 the oxgyen storage shed and of the areas cited at K56. Quality Review completed on 03/10/16 - DA			
K 0025 SS=D Bldg. 04	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier 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 could affect staff only. Findings include:	K 0025	**HEALTHWIN REQUESTS CONSIDERATION FOR A DESK FOR REVIEW FOR ALL CITATIONS. Corrective Action:** The ceiling penetrations in the Therapy Electrical Room were sealed with fire wool. **How Others Identified/Corrective Action:** No additional penetrations in smoke barriers were identified. **Preventive Measures Put in Place/Monitoring/QI:** Ongoing	03/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	X3) DATE SURVEY COMPLETED
	155153		03/07/2016

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
	Based on observations with the Chief Financial Officer, the Administrator, or the Maintenance Supervisor on 03/07/16 at 10:50 a.m., a three inch by five inch, six inch by one and a half inch, and a three inch by six inch ceiling penetration was discovered in the Therapy Electrical room. Based on interview at the time of observation, the Chief Financial Officer, the Administrator, or the Maintenance Supervisor acknowledged and provided the measurements for each unsealed penetration. The penetration was sealed with fire wool before the tour was completed. 3.1-19(b)		repairs and renovations, affecting smoke barriers, will reviewed by the Maintenance Supervisor, and or Designee, to ascertain that smoke barriers are maintained. Inspection results will be documented on an audit tool and presented to the QI Committee on a quarterly basis.	
K 0056 SS=E Bldg. 04	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. Based on observation, record review and interview, the facility failed to ensure the entire facility was provided with sprinkler	K 0056	**Corrective Action**: A Sidewall spray sprinkler will be installed at the bottom of the newly constructed, noncombustible,	03/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	X3) DATE SURVEY COMPLETED
	155153		03/07/2016

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
	coverage. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems 5-13.6.1 states sidewall spray sprinklers shall be installed at the bottom of each elevator hoistway not more than 2 ft above the floor of the pit. Exception: for enclosed, noncombustible elevator shaft that do not contain combustible hydraulic fluids, the sprinklers at the bottom of the shaft are not required. This deficient practice could affect staff only because no resident is in the addition currently. Findings include: Based on observation and record review with the Chief Financial Officer, the Administrator, or the Maintenance Supervisor on 03/07/16 at 11:40 a.m., an elevator was installed in the new addition. Based on record review of the site plans, the sprinkler plans indicated that no sprinkler head was installed on the bottom of the elevator shaft. Based on interview at the time of record review, the Chief Financial Officer confirmed that the elevator shaft contains hydraulic fluid lines. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray		elevator shaft, which contains hydraulic fluids. The sprinkler shall be installed not more than 2 feet above the floor of the pit. **How Others Identified/Corrective Action:** No additional corrective actions were identified. **Preventive Measures Put in Place/Monitoring/QI:** Ongoing construction projects that require sprinkling are reviewed and approved prior to receiving authorization to construct and occupy. Audit tools for sprinkler installation and repairs have been put into place to review in the quarterly Quality Improvement meeting. **Corrective Action:** The surface mounted, ceiling light in the Janitor's Closet was removed and a flush mount light was installed in the suspended ceiling on 3/7/16. **How Others Identified/Corrective Action:** No additional corrective actions were identified. **Preventive Measures Put in Place/Monitoring/QI:** Ongoing construction and renovation projects that require surface mounted lighting will be reviewed to prior to installation to ascertain that lighting does not potentially interfere with sprinkler heads or spray patterns. Audit tools for sprinkler installation and repairs have been put into place to review in the quarterly Quality Improvement meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	X3) DATE SURVEY COMPLETED
	155153		03/07/2016

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
	pattern for 1 of 1 sprinkler head in the Addition Janitor's Closet was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only. Findings include: Based on observation with the Chief Financial Officer, the Administrator, and the Maintenance Supervisor on 03/07/16 at 10:56 a.m., the spray pattern for the sprinkler head in the Addition Janitor's Closet was located next to ceiling light. Measurements showed the sprinkler head was six inches away from the ceiling lights. The ceiling lights were measured to be one and a half inches lower than the sprinkler head deflector. Based on interview at the time of observation, the Chief Financial Officer, the Administrator, or the Maintenance Supervisor acknowledged the abovementioned condition and provided			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	X3) DATE SURVEY COMPLETED
	155153		03/07/2016

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
	the measurements. 3.1-19(b)			
K 0130 SS=B Bldg. 04	NFPA 101 MISCELLANEOUS Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 Therapy fire barrier wall 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	K 0130	**Corrective Action:** The quarter inch penetration in fire wall identified as the "Therapy Fire Barrier was sealed with approved fire caulk. **How Others Identified/Corrective Action**: No additional corrective actions were identified. **Preventive Measures Put in Place/Monitoring/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 on an audit tool and will be presented to the QI Committee on a quarterly basis.	03/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER HEALTHWIN		STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 device that is designed for the specific purpose. This deficient practice could affect staff only. Findings include: Based on an observation with the Chief Financial Officer, the Administrator, or the Maintenance Supervisor on 03/07/16 at 11:16 a.m., the Therapy fire barrier had a quarter inch penetration around metal support above the drop ceiling. Based on interview at the time of observation, the Chief Financial Officer, the Administrator, or the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement. The penetration was sealed with approved fire caulk before the tour was completed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 B. WING	(X3) DATE SURVEY COMPLETED 03/07/2016

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
	3.1-19(b)			