STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155153	A. BUILDING -- B. WING	04/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/04/24 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Emergency Preparedness survey, Healthwin was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 145 and had a census of 120 at the time of this survey. Quality Review completed on 04/16/24	E 0000	**This plan of correction represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any alleged deficiencies or violations. Furthermore none of the actions taken by the plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiencies. These steps are only included because a plan of correction is required by law. Healthwin requests consideration for a desk review for these citations.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/04/24 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Life Safety Code survey, Healthwin was	K 0000	**This plan of correction represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any alleged deficiencies or violations. Furthermore none of the actions taken by the plan of correction are an admission**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephen Gazdick	CFO	05/02/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	found in not compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. All facility sections were surveyed with Chapter 19, Existing Health Care Occupancies. This two story facility with a basement was determined to be of Type II (000) for the Dining Room and Type II(111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in areas open to the corridors and in 10 of 122 resident rooms. Battery operated smoke detectors were in 112 of 122 resident sleeping rooms. The building is fully protected by a 600 kW diesel-powered generator. The facility has a capacity of 145 with a census of 120 at the time of this survey. All areas where the residents have customary access were sprinklered. Quality Review completed on 04/16/24		**that additional steps should have or could have been taken by the facility to prevent the alleged deficiencies. These steps are only included because a plan of correction is required by law. Healthwin requests consideration for a desk review for these citations.**	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and			

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	sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on record review, observation, and interview, the facility failed to maintain the building construction type in 2 of over 100 rooms. This deficient practice could affect approximately 30 residents and staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:28 p.m. to 5:45 p.m. on 04/04/24, within the second floor wheelchair washing area was a wall opening that	K 0161	**Corrective Action:** It is the policy of Healthwin to maintain existing fire barriers and building construction type. The identified 6 ½ '' x 8 ¼" wall opening in the second floor wheelchair washer room and the 9" x 7" hole in the old wash room on the first floor across from room 139 is being repaired utilizing appropriate fireproof materials. A photo of wash room will be uploaded when	05/06/2024

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	measured approximately 6-1/2 inches by 8-1/4". The opening was covered by a sheet of a thin piece of wood. When the wood was removed, the opening led to the attic space above the dining area on the first floor. According to floor plans obtained by the Maintenance Director during the survey, the dining room was listed as a type II-B construction (Type II (000)) while the remaining building was Type II-A (Type II (111)). The construction type between the two areas were not maintained. Based on interview at the time of observation and record review, the Maintenance Director stated he was unaware how long the hole had been there. Later during the survey, the Administrator stated that the room used to be used for video projection and would go into the dining room before the remodel took place. Furthermore, a 9" by 7" inch hole was observed in the wall above the door in an old washroom on the first floor, across from resident room 139. Exposing the attic space. The construction type was designated Type II (111). Based on interview at the time of observation, the Maintenance Director stated that the hole has been there for a while and the room was sealed off in the past. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		complete. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional wall penetrations were discovered, based upon inspection. **Preventive Measures Put In Place:** An in-service was conducted with the Maintenance Staff pertaining to the maintenance of fire barriers. All new repairs or construction projects that could impact fire barriers will be inspected by the Maintenance Supervisor or Designee. **Monitoring and QI:** Inspection results will be reviewed by the QI Committee on a quarterly basis.	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in			

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	accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure 1 of 4 stairways maintained a one-hour fire rating. LSC 19.3.1.1 Protection of Vertical Openings, states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect approximately 30 residents and staff. Findings include: Based on observation with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., material used for part of the second floor east/central stairwell was oriented strand board (OSB). When at the roof level of the stairway the OSB board was used to seal up space between the second drop ceiling and top floor. This did not maintain a 1-hour fire resistance rating construction in the stairwell enclosure. Based on interview at the time of record review, the Maintenance Director confirmed that part of the ceiling construction was made up of OSB board which did not maintain the required fire rating. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0311	**Corrective Action:** It is the policy of Healthwin to maintain required fire resistance ratings. The OSB board discovered in the East/Central stairwell is being covered with appropriate materials in order to maintain the required fire resistance rating. Photos will be forwarded when complete. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional areas were discovered that did not meet required fire ratings, based upon inspection. **Preventive Measures Put In Place:** An in-service was conducted with the Maintenance Staff pertaining to the need to maintain required fire resistance rating in the vertical openings of the building. All new repairs or construction projects that could impact the vertical openings of the building will be inspected by the Maintenance Supervisor or Designee. **Monitoring and QI:** Inspection results will be reviewed by the QI Committee on a quarterly basis.	05/06/2024
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

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	Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 Northwest Wing soiled utility rooms were protected as a hazardous area with a self-closing door that would automatically latch into the frame. This deficient practice could affect approximately 15 residents and staff. Findings include:	K 0321	**Corrective Action:** It is the policy of Healthwin to ensure that doors to designated hazardous areas close utilizing a self-closing device and latch into the frame. The door closer to the second floor soiled utility room on the Northwest unit was adjusted so that it	05/02/2024

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	Based on observations the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., the Northwest Wing of the second floor soiled utility (which contained multiple barrels of trash and soiled linen) was equipped with a self-closing device, but the door did not latch into the frame after testing three times. Based on interview at the time of record review, the Maintenance Director confirmed that the door did not completely latch into the frame and stated that he will get it taken care of. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		automatically latches into the frame. **How Others Identified/Corrective Action**: No additional residents were potentially at risk. No additional doors to designated hazardous areas were found be out of compliance with closing standards. **Preventive Measures Put in Place**: An in-service shall be conducted for all staff concerning the need for all doors to positively latch into frames. Door audits will be completed by the Maintenance Department on a monthly basis for a period of 6 months. **Monitoring and QI:** The results of the monthly audits will be reviewed by the QI Committee on a quarterly basis.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			

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	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was properly maintained. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect approximately 5 staff and an unknown number of residents.	K 0324	**Corrective Action:** It is the policy of Healthwin to ensure that the kitchen hood exhaust system and hood fire suppression systems are properly maintained. Other than the note on the contractor inspection report, indicating the exhaust fan was not working, we show no record of the fan being out of service at that time. The fan has been inspected and tested by our maintenance department and is in good working order. A grease pan has been installed underneath the kitchen range hood and the suppression system nozzle above the deep fryer has been adjusted to cover the deep fryer. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional items of concern were noted on the last inspection report. **Preventive Measures Put in Place**: Inspection reports will be reviewed and signed by both the Maintenance Supervisor and CFO to ensure any noted issues of concern are addressed. **Monitoring and QI:** Noted issues of concern will be reviewed by the QI Committee on a quarterly basis.	05/01/2024

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	Findings include: Based on record review with the Maintenance Director and Administrator on 04/04/24 between 09:14 a.m. and 1:13 p.m., a hood exhaust cleaning report titled Service Report dated 01/28/24 indicated that before and after the kitchen cleaning, under the section "fan(s) operating" and "Fan(s) Testing & Working", the inspection company had listed results as "no". It could not be determined if the kitchen fans had been inspected or did not operate at the time of cleaning. Based on interview at the time of record review, the Maintenance Director stated that around the time of cleaning, the belt for one of the exhaust motors went bad and had to be replaced, however he was unsure if the company had found similar results or if it's a documentation error. This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect approximately 5 staff and an unknown number of residents.			

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:28 p.m. and 5:45 p.m. on 04/04/24, two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. Noticeable grease was found along both sides of the kitchen exhaust system. Based on interview at the time of observation, the Maintenance Director was unsure where the containers were and did acknowledge the presence of grease along the exhaust hoods. Later during the exit conference, the Administrator confirmed that there are designated drip trays within the kitchen, but she was unsure why they weren't there during the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. This deficient practice could affect approximately 5 staff and an unknown number of residents.			

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	Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., a deep fat fryer in the kitchen was not covered by the suppression system. The suppression nozzle above the fryer was pointed away and behind the deep fryer. Based on interview at the time of observation, the Maintenance Director acknowledged that the fryer was not covered by the suppression system. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in			

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	sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 1 of 1 alcohol-based hand sanitizer dispenser in the East 1 lounge was not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect approximately 12 residents and staff. Findings include: Based on observation with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in the resident lounge area within the East 1 hall. Based on interview at the time of observation, the Maintenance Director acknowledged that the hand sanitizer was near the outlet. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0325	**Corrective Action:** It is the policy of Healthwin to ensure that alcohol based hand rub sanitizer dispensers are properly installed. The East 1 alcohol based hand rub sanitizer dispenser was relocated so that it was not within 1 inch of an ignition source. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional improperly installed alcohol based hand rub sanitizers were identified, based upon inspection. **Preventive Measures Put in Place**: An in-service shall be conducted with the Maintenance Staff concerning the proper installation of alcohol based hand rub sanitizer dispenser installations. The Maintenance Supervisor or Designee shall inspect new installations or relocations of alcohol based hand rub sanitizer dispensers to ensure they are installed properly. **Monitoring and QI:** Any issues discovered will be reported to the QI Committee.	04/29/2024

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HEALTHWIN	20531 DARDEN RD SOUTH BEND, IN 46637

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K 0345 SS=F Bldg. 01	3.1-19(b) NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure water flow devices for 1 of 1 fire alarm systems were inspected, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72 Table Testing Frequencies 14.4.5.15(7)(m) requires water flow devices to be inspected and tested annually. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 04/04/24 between 09:14 a.m. and 1:13 p.m., the annual fire alarm report dated 01/26/24 listed approximately nine heat detectors and smoke detectors were either only visually inspected or not tested at all during the annual inspection. The inspection company had either stated that the devices were unable to be accessed or not tested based off of customer request. No other documentation could be found indicating if those devices have had functional testing done within the past year. Based on interview at the time of record review, the Maintenance Director acknowledged the missing	K 0345	**Corrective Action:** It is the policy of Healthwin to ensure that the automatic fire alarm system is inspected and that all noted deficiencies are corrected by qualified maintenance personnel or a qualified contractor. Testing of the non-tested devices has been scheduled to be completed by qualified contractors on 5/2/24. Copies of the proposals have been attached. Final documentation will be forwarded upon completion. **How Others Identified/Corrective Action**: No additional residents were potentially at risk. No other uncompleted deficiencies were identified. **Preventive Measures Put in Place**: The Maintenance Supervisor, the Chief Financial Officer, and the Administrator will document review of all fire alarm system inspection reports to ensure noted deficiencies are	05/02/2024

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	devices and was unsure if they have been tested since. Later during record review, the Chief Financial Officer (CFO) was able to be contacted via phone and stated he was unsure why the devices were not tested. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		completed. **Monitoring and QI:** Noted issues of concern will be reviewed by the QI Committee on a quarterly basis.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to maintain 1 of 1 automatic sprinkler installations for the facility. NFPA 13 9.2.3.5.1 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler	K 0351	**Corrective Action:** It is the policy of Healthwin to ensure that the facility is protected by an automatic sprinkler system in accordance with NFPA 13 and	05/10/2024

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	drop, or sprig shall not exceed 24 in (610 mm) for steel pipe or 12 in (305 mm) for copper tube. This deficient practice could affect approximately 10 staff and residents. Findings include: Based on observation during a tour of the facility on 04/04/24 between 1:28 p.m. and 5:45 p.m. with the Maintenance Director, exposed sprinkler piping was noticed installed in the ceiling of the Activities Lounge within the business hallway near therapy. When observed further, the distance between the arm over and the nearest support hanger was approximately 30 inches. Based on interview at the time of observation, the Maintenance Director acknowledged the distance was greater than two feet which is the allowed distance. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure proper operation and installation for 4 of 10 sprinkler heads. NFPA 13, 2010 edition section 8.5.3.4.2 states the minimum distance permitted between sprinklers shall comply with the value indicated in the applicable section for each type or style of sprinkler. Table 8.6.2.2.1(a) lists protection areas and maximum spacing of standard pendant and upright spray sprinklers for light hazards. Table 8.6.2.2.1(a) indicates maximum spacing of 15 feet. This deficient practice could affect approximately 15 residents and staff. Findings include:		that sprinklers are spaced based upon their type or style. The additional pipe support hanger will be installed in the Activities lounge by a qualified contractor no later than 5/10/24 so that the 24" requirement is met. Support has been attached. The sprinklers identified as being spaced at a distance greater than 15' are Quick-Response Extended Coverage Concealed Sprinklers Model G4 XLO QREC SIN R4441 which provide coverage protection to 20 ft. x 20 ft. for light hazard occupancies. Information pertaining to theQuick-Response Extended Coverage Concealed Sprinklers and their approved use at Heathwin has been attached. **How Others Identified/Corrective Action**: No additional automatic sprinkler system installation issues were identified, based upon inspection. **Preventive Measures Put in Place**: Licensed contracts will continue to be used for any new automatic sprinkler system installations. **Monitoring and QI:** Licensed contracts will continue to be used for any new automatic sprinkler system installations.	

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	Based on observation during a tour of the facility with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., two standard pendant sprinkler heads, one located in front of the Northwest unit on the second floor nurse's desk and the next one down towards the double corridor doors, towards the elevator, were measured to be approximately 18 feet between the two. Furthermore, the corridor in front of the central elevators on the second floor had two standard pendant sprinkler heads spaced approximately 20 feet apart from each other. Based on interview at the time of observation, the Maintenance Director acknowledged that the aforementioned sprinkler heads were spaced more than 15 feet and was unaware they were over the required amount. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review of the sprinkler semi-annual report titled "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" dated 12/13/23 with Maintenance Director and Administrator on 04/04/24 between 09:14 a.m. and 1:13 p.m., under the deficiencies section on page one of the report; gauges had been inspected which were dated 2017 and due for replacement. Based on interview with the Maintenance Director during record review, he stated he was unaware if the sprinkler deficiencies have been resolved. A copy of an	K 0353	**Corrective Action:** It is the policy of Healthwin to ensure that the facility's Automatic Sprinkler System is tested and maintained in accordance with NFPA 25. The gauges that were due for replacement were replaced on 3/22/24, at the time of the quarterly inspection. Support has been attached. The flexible conduit cable zip ties tied to the sprinkler pipes in the Central supply room have been removed. The ceiling tile in room 268 was replaced. **How Others Identified/Corrective Action**: No additional residents were potentially at risk. No additional materials were found to be resting or hung from sprinkler piping, or ceiling tiles with penetrations near sprinkler heads were discovered, based upon inspection. **Preventive Measures Put in Place**: All new repairs or construction projects that could impact ceiling tiles or sprinkler piping will be inspected by the Maintenance Supervisor or Designee. **Monitoring and QI:** The results of these inspections will be documented and will be presented to the QI Committee on a quarterly basis.	04/05/2024

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	email chain dated 03/15/24 stated that the sprinkler company was scheduled to be out March 25th. Later during the survey, the Administrator was able to get ahold of the Chief Financial Officer (CFO) for clarification on the work for the sprinkler system. The CFO confirmed that the sprinkler company was supposed to be out the previous week and deficiencies were found during the inspection, however they did not show up. It was unable to be determined if the repairs have been made. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 4 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., the Central Supply room on the second floor contained flexible conduit cable zip-tied to sprinkler pipes across the entire area. Based on interview at the time of observation, the Maintenance Director			

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	acknowledged the aforementioned issue and was unsure why the cable was zip-tied to the sprinkler pipe. Findings were reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., within resident room 268, a ceiling tile had an approximate 1/4" penetration within four inches from the nearest sprinkler head. This could delay the activation of the sprinkler head in an event of a fire. Based on interview at the time of observation, the Maintenance Director confirmed the ceiling penetration which could delay sprinkler activation. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. 1. Based on observation and interview, the facility failed to ensure 1 of 8 doors to the corridor would completely resist the passage of smoke. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resists the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment for the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or flames in window assemblies. This deficient practice could affect approximately 10 residents, as well as staff and visitors Findings include: Based on observation on 04/04/24 between 1:28	K 0363	**Corrective Action:** It is the policy of Healthwin to ensure that all corridor doors do not contain impediments that would prevent the door from closing; positively latch into the frame; contain appropriate closing hardware; and are designed to prevent the passage of smoke. The identified restroom door located on Bridgeview unit was been repaired. The items that prevented the utility/ice room door near room 208 were removed. A new door is being is installed behind the reception desk and latching hardware has been re-installed on the old washroom across from resident room 139. Photos of the newly installed door will be forwarded upon completion. **How Others Identified/Corrective Action**: No additional residents were potentially at risk. Based upon inspection, no additional corridor doors were identified that did not meet established NFPA standards. **Preventive Measures Put in Place:** An in-service was conducted for the Maintenance staff pertaining to Fire Safety / NFPA standards related to corridor doors and an all staff in-service was conducted pertaining to corridor doors. All corridor doors will be inspected on a monthly basis for a period of six months. **Monitoring and QI:** The results of these inspections	05/06/2024

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	p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director, the restroom door located within Bridgeview hall on the second floor had a circular penetration above the door handle that went through the door that measured approximately 1/2" in diameter. Based on interview at the time of observation, the Maintenance Director acknowledged the door penetration and stated that it would have to be filled in. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 1 of 3 clean utility/ice room doors. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., the clean utility/ice room corridor door across from the unit nurse's desk and resident room 208 was propped open by a step stool and a cardboard box. Based on interview at the time of observation, the Maintenance Director agreed the door was propped open and moved the items so the door could close. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		will be documented and will be presented to the QI Committee on a quarterly basis.	

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	3. Based on observation and interview, the facility failed to ensure 2 of 12 corridor doors near the main entrance were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., a storage area, which used to be a safe, was located in the area behind the reception desk. The area behind the reception desk was not separated from the corridor. The door to the storage area did not fully close and latch. The latching mechanism had been deactivated and door made to not completely close for safety. Based on interview at the time of observation, the Maintenance Director stated that they had deactivated the latch because if someone latched themselves inside, they would not be able to get out. Furthermore, the old washroom on the first floor near the main lobby across from resident room 139 could not latch into the frame due to latching hardware also being removed. Based on interview at the time of observations, the Maintenance Director confirmed that the doors do not latch into the frame. He further stated that both doors had the latching hardware purposely removed. Furthermore, the corridor door to an old washroom, located across from resident room 139 had latching hardware removed and was locked with an external padlock. When the padlock was removed, the door was unable to latch. Based on interview, the Maintenance Director stated that the hardware for the door had been removed due to a previous			

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	issue and acknowledged the door did not latch. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical panels in Northwest Hall was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the service hall. Findings include:	K 0511	**Corrective Action:** It is the policy of Healthwin to ensure that all electric panels are locked. The identified unlocked electric panel located next to the Northwest dirty linen room was re-locked at the time of discovery. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional unlocked electric panels were discovered, based upon inspection. **Preventive Measures Put in Place:** An in-service was conducted for with the Maintenance Staff concerning need for all electric panels to be locked. Electric panel audits will be completed by the Maintenance Department on a monthly basis for a period of 6 months. **Monitoring and QI:** The results of the monthly	04/29/2024

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	Based on observation with Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m., the electrical panel next to the dirty linen room of the Northwest Hall on the second floor was unlocked when tested. The panel included breakers to the lights and outlets in resident rooms of the Northwest wing. Based on interview at the time of observation, the Maintenance Director confirmed the electrical panel was unlocked and was able to secure it before the end of the survey. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		audits will be reviewed by the QI Committee on a quarterly basis.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING 01 B. WING	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 3 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 04/04/24 between 1:28 p.m. and 5:45 p.m. 12:00 p.m., two refrigerators (both high power draw equipment) were plugged into and supplied power by a power strip in the Nursing Supervisors office on the second floor. Based on interview at the time of observation, the Maintenance Director agreed that the fridges were plugged into the power strip. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)	K 0920	**Corrective Action:** It is the policy of Healthwin to ensure that power cords and extension cords are installed properly and used in a safe manner. The high draw pieces of equipment that were plugged into the power strip in the Nursing Supervisor's office were unplugged from the power strip and plugged directly to the existing wall mounted electrical outlets. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional improperly used power strips were discovered to be in use. **Preventive Measures Put in Place**: An in-service will be conducted for the Maintenance Staff pertaining to Electrical Safety and the necessity to review all power strips in use to ensure electrical safety standards are maintained. All new purchases or relocations of high draw pieces of equipment will be inspected by the Maintenance Supervisor or Designee to ascertain that units are not plugged into a power strip. **Monitoring and QI:** Inspection results will be reviewed by the QI Committee on a quarterly basis.	04/29/2024