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	02/07/2023

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: 02/07/23 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 153 and had a census of 103 at the time of this survey. Quality Review completed on 02/08/23	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: 02/07/23 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 J Gazdick	CFO	02/24/2023

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 (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in areas open to the corridors and in 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 153 with a census of 103 at the time of this survey. All areas where the residents have customary access were sprinklered. Quality Review completed on 02/08/23		**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 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 17 exit signs were	K 0293	**Corrective Action:** It is the policy of Healthwin to ensure exit and	02/23/2023

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	continuously illuminated. This deficient practice could affect 20 residents who use the Business Hall stairway. Findings include: Based on observations on 02/07/23 during a tour of the facility from 12:23 p.m. to 3:23 p.m. with the Chief Financial Officer, the Business Hall stairway exit sign above the exit door was not illuminated. Based on an interview with the Chief Financial Officer at the time of observation, they agreed that the exit light was out and needed repair. Findings were discussed with the Chief Financial Officer at exit conference. 3.1.19(b)		directional signs are displayed with continuous illumination. The bulbs in the business hall stairwell exit sign were replaced on 2/8/23. **How Others Identified/Corrective Action: All potential** No additional residents were potentially at risk. No additional non-illuminated exit or directional signs were discovered. **Preventive Measures Put In Place:** An in-service shall be conducted with the Maintenance Staff concerning the need to monitor illuminated exit and directional signage. **Monitoring and QI:** All illuminated, non-battery operated exit signs, will be added to the monthly, battery operated emergency lighting, audit. The results of the monthly lighting audits will be reviewed by the QI Committee on a quarterly basis. **Date of Completion**: 2/23/23	
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			

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	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. 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 Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect all kitchen staff Findings include: Based on observation with the Chief Financial Officer on 02/07/23 between 12:25 p.m. and 3:23 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher. Based on interview, Kitchen staff #1 was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; Pull the ring to extinguish. The employee failed to instruct using the correct fire extinguisher for a hood grease fire and did not know where the UL 300 hood pull station was located. The Chief Financial Officer acknowledged the Cooks response and stated all kitchen staff will be informed on proper response. Findings were discussed with the Chief Financial Officer at exit conference.	K 0324	**Corrective Action:** It is the policy of Healthwin to ensure that staff are instructed in the use of the UL 300 hood system and use of K fire extinguishers. **How Others Identified/Corrective Action:** No residents were affected. An in-service shall be conducted with Dietary Staff pertaining to the use of the UL 300 hood system and the use of K fire extinguishers. **Preventive Measures Put In Place:** An in-service shall be conducted with the Dietary Staff pertaining to the use of the UL 300 hood system and the use of K fire extinguishers. **Monitoring and QI:** The use of the UL 300 hood system and the use of K fire extinguishers will be added to the competency standards for all dietary staff. Completion of annual competencies are reviewed by Healthwin's Staff Education Coordinator. **Date of Completion**: 2/24/23	02/24/2023

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K 0353 SS=E Bldg. 01	3.1-19(b) 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 _____ 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 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	K 0353	**Corrective Action:** It is the policy of Healthwin to ensure that the automatic sprinkler system is inspected on a quarterly basis and all noted deficiencies are corrected by qualified maintenance personnel or a qualified contractor. Verbal approval to replace the dry sprinkler heads in the “old cooler and freezer area” was given to the contractor on 1/26/23. Written documentation concerning the approval to replace the sprinkler heads has been attached. The sprinkler heads will be replaced no later than 3/17/23. **How Others**	03/17/2023

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	shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all kitchen staff. Findings include: Based on records review of "Form for Inspection, Testing, and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 06/30/22 with Chief Financial Officer on 02/07/22 at 10:35 a.m., under the deficiencies section on page one of the report; it stated "Old cooler and freezer have heads older than 10 years old." The sprinkler company listed that the sprinkler heads were dry heads required to be tested/replaced after 10 years. Based on interview at the time of record review, the Chief Financial Officer acknowledged there was no written documentation available to show the sprinkler system had been repaired since the last inspection on 06/30/22. They stated that they are in the process for fixing the deficiency with the sprinkler company. Findings were discussed with the Chief Financial Officer at exit conference. 3.1-19(b)		**Identified/Corrective Action**: No residents were at risk. No other uncompleted deficiencies were identified. **Preventive Measures Put in Place**: The Maintenance Supervisor and the Chief Financial Officer will document review of all sprinkler system inspection reports to ensure noted deficiencies are completed. **Monitoring and QI:** The Administrator will also document review of all sprinkler inspection reports. **Date of Completion:** 3/17/23	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 15 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings	K 0761	**Corrective Action:** It is the policy of Healthwin to ensure that all fire door assemblies are inspected, with written documentation maintained, on an annual basis. The fire door assembly for the oxygen storage area passed inspected on 2/8/23. **How Others**	02/08/2023

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	required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly		**Identified/Corrective Action:** No additional residents were potentially at risk. No additional non-inspected fire door assemblies were discovered. **Preventive Measures Put in Place**: The fire door assembly for the oxygen storage area was added to the list of doors which required annual inspection. **Monitoring and QI:** All fire door assemblies are inspected on an annual basis. Documentation of said inspections will be maintained. Inspection results will be reviewed by the QI Committee on a quarterly basis. **Date of Completion**: 2/8/23	

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	have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on record review of the "Fire Door Inspection" form with the Chief Financial Officer on 02/07/23 between 09:52 a.m. and 12:24 p.m., the form listed smoke and fire door assemblies inspected annually. Based on observation during the tour between 12:25 p.m. and 3:23 p.m., there was a one and a half hour fire door assembly located for the oxygen storage room. Based on interview at the time of records review and observation, the Chief Financial Officer stated the separation door was not on the inspection list, was not inspected in the last year. Findings were discussed with the Chief Financial Officer at exit conference.			
K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 2 of 2 portable space heaters were not used in the facility. This deficient practice could affect up to 4 staff in the Nurse Practitioner and Dietary Supervisor Office	K 0781	**Corrective Action:** It is the policy of Healthwin to ensure that all portable heaters used on non-sleeping staff and employee areas do not exceed 212 degrees Fahrenheit and are approved by	02/24/2023

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	Findings include: Based on observations during a tour of the facility with the Chief Financial Officer on 02/07/23 between 12:25 p.m. and 3:23 p.m., portable space heaters were located in the Dietary Supervisor Office and Nurse Practitioner's Office. The facility allows portable heaters, but not in areas of patient care and have to be tested and marked by maintenance staff before use. Policy states portable heaters are to be removed if not marked or tested. At observation, both portable space heaters were not marked nor known to be tested. At interview during observation, the Chief Financial Officer agreed the two heaters had not been tested and should have been removed. Findings were discussed with the Chief Financial Officer at exit conference. 3.1-19(b)		Healthwin's Maintenance Department, which is evidenced by the appropriate approval sticker. The portable space heaters were removed on 2/7/23. The portable space heaters were inspected and appropriately marked as approved on 2/8/23. **How Others Identified/Corrective Action:** No residents were affected. No additional unapproved portable heaters were identified, based upon inspection. **Preventive Measures Put in Place:** An in-service shall be conducted for all staff concerning the use of portable heaters used in non-sleeping staff and employee areas. Portable heater 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 heater audits will be reviewed by the QI Committee on a quarterly basis. **Date of Completion**: 2/24/23	
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			

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	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 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 2 of 2 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could staff in the Nursing Supervisor Office and area near Room 109. Findings include: Based on observation with the Chief Financial Officer on 02/07/23 between 12:25 p.m. and 3:23 p.m., in the Nursing Supervisor office and the Nursing Desk next to room 109, two power strips used to power equipment, were not secured, and were dangling from the outlet on the wall. This	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 dangling power strip in the Nursing Supervisor's office was replaced with a properly installed power on 2/8/23. The power strip at the nurse's desk was fixed upon observation on 2/7/23. Both power strips had been installed by an outside contractor at the time the printers/copiers were recently installed. **How Others Identified/Corrective Action:** No additional residents were potentially at risk. No additional improperly installed power strips were discovered to be in use. **Preventive Measures Put in Place**: An in-service will be conducted for the Maintenance	02/21/2023

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	condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Chief Financial officer agreed the power strips were dangling, not secured, and stated the power strips will need to be mounted or set on the floor. The power strip at the nurses desk was fixed upon observation. This finding was reviewed with the Chief Financial Officer during the exit conference. 3.1-19(b)		Department pertaining to Electrical Safety and the necessity to review all outside contractor equipment installations to ensure electrical safety standards are maintained. **Monitoring and QI:** All installations of power strips and electrical equipment by outside contractors will be inspected by the Maintenance Supervisor or Designee to ascertain that electrical cords and power strips are installed in a proper and safe manner. Inspection results will be reviewed by the QI Committee on a quarterly basis. **Date of Completion**: 2/21/23	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual			

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	cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 10 of 10 empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 10 staff in one smoke compartment. Findings include: Based on observations with the Chief Financial Officer on 02/07/23 between 12:25 p.m. and 3:23 p.m., the oxygen storage room on the second floor contained four racks that contained cylinders, but were not segregated from full and empty. Based on interview at the time of observation, the Chief Financial Officer stated that the cylinders were unable to be determined if full and empty and did not segregate with signage.	K 0923	**Corrective Action:** It is the policy of Healthwin to ensure that empty oxygen cylinders are segregated from full cylinders and are marked to avoid confusion. **How Others Identified/Corrective Action:** All residents were potentially at risk. All oxygen cylinders were inspected, segregated by content, and appropriately marked. **Preventive Measures Put in Place:** The second floor oxygen room will be inspected on a weekly basis for 4 weeks and a monthly basis for 5 months. An audit form will be completed at the time of each inspection. An in-service pertaining to oxygen	02/23/2023

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	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The findings were reviewed with the Chief Financial Officer during the exit conference.		safety and segregation of cylinders will be conducted for all staff that utilize the second floor oxygen room. **Monitoring and QI:** The results of the monthly audits will be reviewed by the QI Committee on a quarterly basis. **Completion Date**: 2/23/23	