Bud Johnson

PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-039

04/09/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155153		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIER WIN HEALTH & REHABILITATION	20531 I	ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637	
(X4) ID PREFIX TAG E 0000	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/20/2025 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Emergency Preparedness survey, Healthwin Health & Rehabilitation was found not 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 98 at the time of this survey. Quality Review conducted on 03/24/25	E 0000	K0000 We here at the facility are respectfully requesting this agency consider paper compliance for the following plot of correction as opposed to a survey visit. We are willing to submit any and all documenta as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby providing our plan of correction The submission of this plan of correction does not constitute admission or an agreement by provider of the truth of facts alleged or corrections set forth the statement because of deficiencies. This was prepare and submitted because of requirements under State and Federal Law. Please accept the plan of correction as our credit allegation of compliance. We are requesting desk review for compliance.	tion ving n. an vihe on ad his table
E 0039 SS=F Bldg	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the Emergency Preparedness Plan (EPP) at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale	E 0039	E039 We here at the facility are respectfully requesting this agency consider paper compliance for the following plof correction as opposed to a	
LABORATOR	I RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Any defiency statement 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 disclodays 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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Administrator

	NT OF DEFICIENCIES OF CORRECTION	ES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (IDENTIFICATION NUMBER A. BUILDING B. WING		(X3) DATE COMPI 03/20	LETED		
NAME OF I	PROVIDER OR SUPPLIER	}	•		ADDRESS, CITY, STATE, ZIP COD	•	
					DARDEN RD		
HEALTH	WIN HEALTH & RE	EHABILITATION		SOUTH	H BEND, IN 46637		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	exercise that is com	•			survey visit. We are willing to		
		ity-based exercise is not			submit any and all documenta	tion	
	· · · · · · · · · · · · · · · · · · ·	an annual individual,			as requested to assure our		
	facility-based funct				credible compliance with the	_	
		ty experiences an actual natural			deficiencies noted in the follow	ving	
		gency that requires activation			CMS-2567. We are hereby		
		lan, the LTC facility is exempt			providing our plan of correctio		
		ext required full-scale in a			The submission of this plan of		
	-	or individual, facility-based			correction does not constitute		
	full-scale functional exercise for 1 year following				admission or an agreement by	/ the	
	the onset of the actual event.				provider of the truth of facts		
	(ii) Conduct an additional exercise that may				alleged or corrections set forth	n on	
	include, but is not limited to the following:				the statement because of		
	a. A second full-scale exercise that is				deficiencies. This was prepare	ed	
	-	or an individual, facility-based			and submitted because of		
	functional exercise.				requirements under State and		
	b. A mock disaster				Federal Law. Please accept t		
	_	ise or workshop that is led by a			plan of correction as our credi		
		ides a group discussion, using			allegation of compliance. We	are	
		y-relevant emergency scenario,			requesting desk review for		
	_	m statements, directed			compliance.		
	challenge an emerg	red questions designed to			#1	اء ما	
		FC facility's response to and			The facility immediately review		
		ation of all drills, tabletop			the Emergency Preparedness		
		rgency events, and revise the	- [Training and Testing program	-	
		gency plan, as needed in			identification of the deficiency	•	
	accordance with 42				Staff identified as not having	201	
		rice could affect all residents,			received the required emerge	icy	
	staff and visitors.	ice could affect all fesidents,			preparedness training were immediately scheduled for and	4	
	starr and visitors.				completed updated training,	J	
	Findings include:				including documentation of		
	i manigs metade.				completion.		
	Based on record rev	view and interview with the			#2		
		Director of Maintenance at			All current residents have the		
		0/25, the facility was unable to			potential to be affected by		
		tion of any exercises of the			inadequate staff training and		
	*	ing the past 12-month period.			testing procedures. A facility-v	vide	
		Administrator stated he did not			audit was conducted to deterr		
	· · · · · · · · · · · · · · · · · · ·	n of any exercises conducted			staff compliance with emerger		
	I mayo documentation	is of any excitions conducted	ı		I stati compliance with emerger	юy	I

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	OF CORRECTION	IDENTIFICATION NUMBER 155153	A. BUILDING B. WING	onstruction 	COMPLETED 03/20/2025
	PROVIDER OR SUPPLIER		20531 [ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	conduct exercises so This finding was rev and Director of Mai conference.	viewed with the Administrator intenance at the exit		preparedness training requirements. No residents we found to have been directly harmed. #3 The Emergency Preparedness Coordinator will maintain a tra log and ensure all staff receive initial and annual emergency preparedness training. A tracking system will be implemented to monitor due d for training and drill participation. The facility will conduct at least two emergency drills per year being full-scale), and staff participation will be documente and reviewed for compliance. #4 The Administrator or designed audit training records monthly six months to ensure 100% compliance. Results will be reported and reviewed at monthly QAPI meetings. Any instances of noncomplian will be addressed immediately with re-education and correctinaction.	ates on. ot (one ed e will for
E 0041 SS=F Bldg	Hospital CAH and	(e), 485.542(e), 485.62 LTC Emergency Power	E 0041	E044	04/22/2025
	interview, the facilit generator annually t NFPA 110, 2010 Ec Emergency and Star	ation, record review and by failed to exercise the o meet the requirements of lition, the Standard for hadby Powers Systems, Chapter states diesel generator sets in	E 0041	We here at the facility are respectfully requesting this agency consider paper compliance for the following p of correction as opposed to a	

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Event ID:

 $NC5G21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000073$

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING		COMPL	ETED
		155153	B. W	ING _		03/20/	/2025
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			DARDEN RD		
HEVLTH	WIN HEALTH & RE	HARILITATION			H BEND, IN 46637		
HEALIN	VVIIN LIEALITI & RE			30016	1 DEIND, IIN 40001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ercised at least once monthly,			survey visit. We are willing to		
		0 minutes, using one of the			submit any and all documenta	ation	
	following methods:				as requested to assure our		
		aintains the minimum exhaust			credible compliance with the		
		recommended by the			deficiencies noted in the follow	wing	
	manufacturer				CMS-2567. We are hereby		
		g temperature conditions and at			providing our plan of correction		
	not less than 30 percent of the EPS (Emergency				The submission of this plan of		
	Power Supply) nameplate kW rating.				correction does not constitute		
	Section 8.4.2.3 states diesel-powered EPS				admission or an agreement b	y the	
	installations that do not meet the requirements of				provider of the truth of facts		
	8.4.2 shall be exercised monthly with the available				alleged or corrections set fort	n on	
	EPSS (Emergency Power Supply System) load and				the statement because of		
		nnually with supplemental			deficiencies. This was prepare	ed	
		Test) at not less than 50 percent			and submitted because of		
	_	ate kW rating for 30 continuous			requirements under State and	l	
		less than 75 percent of the EPS			Federal Law. Please accept		
	-	ng for 1 continuous hour for a			plan of correction as our cred		
		f not less than 1.5 continuous			allegation of compliance. We	are	
		nt practice could affect all			requesting desk review for		
	residents, staff, and	visitors.			compliance.		
					#1		
	Findings include:				Upon identification of the		
					deficiency, the facility's		
		view and interview with the			emergency generator system		
		Director of Maintenance at			scheduled to be inspected by		
		0/25, the documented load			licensed contractor to ensure	full	
		nthly load tests of the 600-kW			operational status. Any		
	_	ad percentage for the			maintenance issues were		
		erator indicated the generator			resolved, and a full test of the		
	^	s than 30 percent. Based on			generator under load was		
		p.m. a 600-kW diesel generator			successfully completed. No		
		e rear of the facility. Based on			residents were harmed as a r	esult	
		a.m., the Director of			of the deficiency.		
		wledged the generator ran					
		ekly basis but did not achieve			#2		
	_	plate rating. Additionally, the			All residents have the potentia		
		nance stated the facility is			be affected by deficiencies in	the	
	_	load bank test to the contract			emergency power system. A		
	for services.				facility-wide risk assessment	was	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		NSTRUCTION	(X3) DATE : COMPL 03/20/	ETED		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 20531 DARDEN RD SOUTH BEND, IN 46637				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	facility failed to ensume was performed for a generator. NFPA 9 2012 Edition Section (Essential Electrica be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power Sys NFPA 110, Section shall be performed approved by ASTM.	review and interview, the sure an annual fuel quality test the facility's diesel-powered 9, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance undard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient that all residents, staff, and			conducted, and emergency pocoverage for all critical system was verified and no residents wharmed. #3 The facility has contracted with certified electrical provider for monthly generator inspections annual full-load testing in accordance with NFPA 110 and CMS requirements. A preventative maintenance schedule has been developed added to the facility's emerger preparedness binder.	s were n a and and	
	Administrator and I 11:58 a.m. on 03/20 annual fuel quality was available for re 2:15 p.m. a 600-kW in the rear of the far 11:58 a.m., the Dire acknowledged no d fuel quality test was facility is working to for services. 3. Based on observinterview, the facility is working to the services.	view and interview with the Director of Maintenance at 0/25, no documentation of an test for the diesel generator view. Based on observation at 7 diesel generator was observed cility. Based on interview at ector of Maintenance ocumentation of an annual s available and stated the o add the test to the contract ation, record review, and ty failed to document 36-month			Backup logs for generator test (weekly, monthly, and annual) now be reviewed monthly in TI by the Administrator to ensure timely compliance. #4 A monthly audit of emergency power system logs and maintenance reports will be completed for 6 months by the Administrator or designee. Any missed logs, tests, or issu will be addressed within 24 ho and corrective action documer	will ELS es urs nted.	
	emergency generate 99 and NFPA 110. Code, 2012 Edition	generator testing for 1 of 1 ors in accordance with NFPA NFPA 99, Health Care Facilities , Section 6.4.1.1.6.1 states Type tial electrical system power			Findings will be reviewed during monthly QAPI meetings and included in the Emergency Preparedness annual review	ng	

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	PROVIDER OR SUPPLIEF			20531	ADDRESS, CITY, STATE, ZIP COD DARDEN RD BEND, IN 46637		
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	Class X, Level 1 ge NFPA 110, the Star Standby Powers Sy 8.4.9 states Level 1 once within every 3 states Level 1 EPSS for the duration of i 4.2). Section 8.4.9.5 class is greater than to terminate the test Section 8.4.9.5 state test shall be specific 8.4.9.5.3. Section 8 EPS's, loading shal This deficient pract staff, and visitors. Findings include: Based on record rev Administrator and 1 12:03 p.m. on 03/20 emergency generate four continuous hor emergency generate Maintenance at 2:1 generator was obse Based on interview Maintenance acknows available to she generator in the last facility is working to contract for service These findings were	Ill be classified as Type 10, enerator sets per NFPA 110. Indard for Emergency and stems, 2010 Edition, Section EPSS shall be tested at least 36 months. Section 8.4.9.1 In Section 8.4.9.1 It is assigned class (See Section 2 states where the assigned 14 hours, it shall be permitted at after 4 continuous hours. It is et a minimum load for this ed in 8.4.9.5.1, 8.4.9.5.2, or 3.4.9.5.3 states for spark-ignited at the available EPSS load. It is could affect all residents, which will be the available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the diesel fired for was not available for review. It is for the facility at 11:58 a.m., the Director of fiveledged no documentation for was 4-hour test of the to add the load bank test to the state of the to add the load bank test to the state of the to add the load bank test to the state of the facility.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> CC		COMPL	ETED
		155153	B. WI	NG		03/20/2025	
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD DARDEN RD		
HEALTH\	WIN HEALTH & RE	HABILITATION			I BEND, IN 46637		
(X4) ID		STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K 0000	REGULATORY OR	LSC IDENTIFTING INFORMATION	+	TAG			DATE
K 0000							
Bldg. 01							
blug. 01	A Life Safety Code	Recertification and State	K 0	000	K0000		
	-	as conducted by the Indiana	KU	000	We here at the facility are		
	-	th in accordance with 42 CFR			respectfully requesting this		
	483.90(a).	in in accordance with 42 Cl K					
	тоэ. жо(а).				agency consider paper compliance for the following pl	lan	
	Survey Date: 03/20/	2025			of correction as opposed to a		
	Sarvey Date. 03/20/	2023			survey visit. We are willing to	ρυσι	
	Facility Number: 00	00073			submit any and all documenta	tion	
	Provider Number: 1				as requested to assure our	lion	
	AIM Number: 100288820				credible compliance with the		
					deficiencies noted in the follow	ina	
	At this Life Safety (Code survey, Healthwin Health			CMS-2567. We are hereby	virig	
		s found not in compliance			providing our plan of correction	n	
	with Requirements				The submission of this plan of		
	-	, 42 CFR Subpart 483.90(a),			correction does not constitute		
		re and the 2012 edition of the			admission or an agreement by		
		etion Association (NFPA) 101,			provider of the truth of facts	ı ıı ı c	
		SC) and 410 IAC 16.2. All			alleged or corrections set forth	on	
	•	re surveyed with Chapter 19,			the statement because of	1 011	
	Existing Health Car	-			deficiencies. This was prepare	d	
	Existing Health Car	e Occupancies.			and submitted because of	:u	
	This two-story facili	ity with a basement was			requirements under State and		
	-	Type II (000) for the Dining			Federal Law. Please accept the		
		111) construction and was			plan of correction as our credit		
	• • •	he facility has a fire alarm			allegation of compliance. We a		
		detection on all levels			-	ale	
	•	ridors, in areas open to the			requesting desk review for compliance.		
	-	of 122 resident rooms. Battery			Compliance.		
		ectors were in 112 of 122					
	-	oms. The building is fully					
		www.diesel-powered generator.					
	•	pacity of 145 with a census of					
	98 at the time of this						
	70 at the time of this	s sui vey.					
	Quality Review con	ducted on 03/24/25					
	Zaulity Iteview Coll	ducted 011 03/2 1/23					

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	T OF DEFICIENCIES OF CORRECTION	• 1		ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/20/2025	
	ROVIDER OR SUPPLIER		20531	ADDRESS, CITY, STATE, ZIP COD DARDEN RD H BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0222 SS=E	NFPA 101 Egress Doors					
Bldg. 01	failed to ensure the more than 10 exits or residents without a conspecialized security required means of ewith a latch or lock or key from the egrepermitted by LSC 1 arrangements shall 1 with 19.2.2.2.5.2. Taffect residents, staffect residents, staffect residents include: Based on observation Director of Mainten the exit door from the exit door from the resident room 155 or requiring a code, but the exit. At 12:39 p Maintenance stated keypad but it had be knowledge.	the code was posted on the een removed without his viewed with the Administrator	K 0222	We here at the facility are respectfully requesting this agency consider paper compliance for the following profession of correction as opposed to a survey visit. We are willing to submit any and all documents as requested to assure our credible compliance with the deficiencies noted in the following compliance with the deficiencies noted in the following our plan of correction to this plan of correction does not constitute admission or an agreement be provider of the truth of facts alleged or corrections set forth the statement because of deficiencies. This was prepare and submitted because of requirements under State and Federal Law. Please accept the plan of correction as our crediallegation of compliance. We requesting desk review for compliance. #1 On 03/20/2025, immediately following the surveyor's observation, the facility re-post the correct keypad exit code of the magnetic lock located new Room 155 on the 1st Floor Will. The code was placed in clear, visible signage directly above the keypad, in accordance.	post ation wing on. f an y the h on ed this itable are	

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	ROVIDER OR SUPPLIE		20531	ADDRESS, CITY, STATE, ZIP COD DARDEN RD H BEND, IN 46637	•
(X4) ID PREFIX TAG	(EACH DEFICIE	TSTATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				with NFPA Life Safety Code requirements.	
				#2 The Maintenance Director completed a facility-wide aud all egress doors equipped wit magnetic locks requiring a ke or code. All such doors were reviewed to ensure that: Required codes are visit posted, Doors are functioning in manner compliant with safe egress requirements, and No other exits were simple deficient. No additional issues were identified during the audit.	th eypad ibly
				#3 A Preventive Maintenance Checklist has been updated to include monthly visual inspect of all exit doors with keypad of magnetic locking mechanism. The Maintenance Department.	ctions or s. ut has
				been retrained on Life Safety egress requirements, particul regarding: Proper signage for lock exits, The importance of unrestricted means of egress unless allowed under special provisions. Any changes to door locking systems must now be review the Safety Committee and	ed

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AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155153	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2025		
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K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Example 100 and 100 an	xits	K 0271	#4 The Maintenance Director will conduct monthly audits for 6 months to verify that: ·All egress codes remain cle posted, ·Magnetic locking systems function properly, ·Staff are familiar with egres procedures. Results will be reviewed during monthly QAPI and Safety Committee meetings.	early s		
	failed to ensure 4 of were marked with of states the exit disch marked to make cle from the exit dischadeficient practice of visitors in 4 of 7 sm. Findings include: Based on observation Director of Mainter courtyard with a gaway was not marked egress travel. The was connected to seat the end of the exit was located on the was not visible from following exits from	f 12 egress discharge paths lirectional signage. LSC 7.7.3.2 arge shall be arranged and ar the direction of egress travel arge to a public way. This buld affect residents, staff and	K 02/1	We here at the facility are respectfully requesting this agency consider paper compliance for the following pl of correction as opposed to a particle survey visit. We are willing to submit any and all documenta as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby providing our plan of correction The submission of this plan of correction does not constitute admission or an agreement by provider of the truth of facts alleged or corrections set forth the statement because of deficiencies. This was prepare and submitted because of requirements under State and	lan post tion ving n. an the n on		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLET	ΓED
		155153	B. W	TNG		03/20/20	025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			DARDEN RD		
HEALTH	WIN HEALTH & RE	HABILITATION			H BEND, IN 46637		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		of travel to a public way:			Federal Law. Please accept t	this	
	_	e exit from the 1st floor West			plan of correction as our credi	itable	
	Hall next to residen	t room 155 was observed. This			allegation of compliance. We	are	
	was acknowledged	by the Director of			requesting desk review for		
	Maintenance at 12:	43 p.m.			compliance.		
	2. At 12:43 p.m. the	e exit from the hall leading to the			#1		
	front lobby smoke	compartment was observed.			Immediately following the surv	vey,	
	This was acknowled	dged by the Director of			the facility installed permanen	ıt	
	Maintenance at 12:	43 p.m.			directional signage within the		
	3. At 1:18 p.m. the	exit from the business hall to			fenced courtyard, clearly		
	the courtyard was o	bserved. This was			indicating the path to the publ	ic	
	acknowledged by the	ne Director of Maintenance at			way from all courtyard exits. S	Signs	
	1:18 p.m.				were placed at:		
	4. At 1:31 p.m. the	exit from the Therapy lounge			The exit near Room 155	5	
	was observed. This	s was acknowledged by the			(West Hall),		
	Director of Mainter	nance at 1:31 p.m.			The hallway leading to t	he	
					front lobby smoke compartme	ent,	
	This finding was re	viewed with the Administrator			The business hallway ex	xit,	
	and Director of Ma	intenance at the exit			The Therapy Lounge ex	it.	
	conference.				All exit signage is mounted at	eye	
					level, consistent with NFPA 10	01	
	3.1-19(b)				Life Safety Code standards.		
					#2		
					A full facility walk-through was	s	
					conducted by the Maintenanc		
					Director and Administrator to		
					identify any other exits or		
					discharge areas that may lack	(
					appropriate directional signag	e. All	
					other exit discharge areas we	re	
					verified as clearly marked or		
					updated with signage as need	ded	
					to ensure proper egress durin	g an	
					emergency.		
					#3		
					A Life Safety Signage Checkli	ist	
					has been created and will be		
					quarterly to verify the presence	e l	
					and visibility of all directional		
					egress signage, especially for	.	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155153	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIEF		20531	ADDRESS, CITY, STATE, ZIP COD DARDEN RD H BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				outdoor discharge paths. All maintenance staff have beretrained on the requirements marking exit routes under NFF 101. All new construction or change landscaping or pathways that could affect egress visibility we require a Life Safety complian review prior to implementation #4 The Maintenance Director will complete quarterly audits for cyear to confirm signage remain intact, visible, and appropriate located. The results of each audit will be reported at the monthly QAPI Safety Committee meetings. Any missing, damaged, or blocked signs will be corrected within 24 hours and logged in maintenance report.	for PA es to III ce one ns ly oe and	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Me	ans of Egress				
	failed to ensure con of 12 exits. For the exit discharge shall aisles, corridors, rar exit passageways le deficient practice or visitors in 4 of 7 sm. Finding include: Based on observation	on and interview, the facility tinuity of egress lighting for 4 purposes of this requirement, include only designated stairs, mps, escalators, walkways and rading to a public way. This build affect residents, staff and noke compartments.	K 0281	We here at the facility are respectfully requesting this agency consider paper compliance for the following p of correction as opposed to a survey visit. We are willing to submit any and all documenta as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby	post tion ving	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/20/2025 155153 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 20531 DARDEN RD **HEALTHWIN HEALTH & REHABILITATION** SOUTH BEND, IN 46637 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the exit discharge sidewalks from exit doors from The submission of this plan of the West Hall, the connecting hall to the front correction does not constitute an lobby hall, the business hall and the Therapy admission or an agreement by the lounge, did not have egress lighting for portions provider of the truth of facts of the sidewalks from the exit to the public way. alleged or corrections set forth on Based on interview at 1:31 p.m., the Director of the statement because of Maintenance confirmed there were no other deficiencies. This was prepared lighting devices illuminating the sidewalks and and submitted because of acknowledged the lighting at the exit doors did requirements under State and not illuminate the entire egress discharge to a Federal Law. Please accept this public way. plan of correction as our creditable allegation of compliance. We are This finding was reviewed with the Administrator requesting desk review for and Director of Maintenance at the exit compliance. conference. Immediately following the 3.1-19(b) identification of the deficiency, was ordered and placed along the exit discharge sidewalks from the following exits: West Hall (near Room 155), The hallway connecting to the front lobby smoke compartment, The Business Hall, The Therapy Lounge. This action ensured temporary compliance with illumination requirements until permanent lighting could be installed. A full facility lighting assessment was conducted by the Director of Maintenance to review all exterior exit discharge pathways. Any additional locations lacking full pathway illumination to a public way were identified and scheduled for corrective installation. No other areas were found to be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		155153	B. WING 03/20/2025				
	PROVIDER OR SUPPLIE			20531 [ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) deficient at the time of the aug		(X5) COMPLETION DATE
					#3 New permanent outdoor lighti fixtures have been ordered an scheduled for installation alon affected discharge sidewalks. These fixtures will provide continuous illumination, meeti the required minimum of 1 foot-candle, and will be tied in the facility's emergency backupower system. The Maintenance Department been retrained on NFPA 101 requirements for continuous egress lighting. #4 The Director of Maintenance of designee will conduct quarter nighttime inspections of all exterior egress routes to ensulighting is functional and fully illuminating all exit pathways to the public way. Results of inspections will be presented at monthly QAPI ar Safety Committee meetings. Any outages or failures will be addressed immediately, with a maximum 24-hour turnaround repair or replacement.	ng id g the ng to up thas or y ure o nd	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities						
	failed to maintain system in accordar Ventilation and Fin	on and interview, the facility of 1 kitchen extinguishing nee with NFPA 96, Standard for the Protection of Commercial as, Section 10.5.1 states A	K 0:	324	K324 We here at the facility are respectfully requesting this agency consider paper compliance for the following p	lan	04/23/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155153		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIER		20531	ADDRESS, CITY, STATE, ZIP COD DARDEN RD H BEND, IN 46637	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPR DEFICIENCY)	
TAG	readily accessible meshall be located between the floor, be accessionated in a path of hazard protected. A Safety Code, 4.6.12 features obvious to the code, shall be eigen This deficient practionly. Findings include: Based on observationate Director of Mainter the ANSUL "Pull Sabove the floor next kitchen. Based on in Director of Mainter measurement as me	neans for manual activation ween 42 in. and 48 in. above ble in the event of a fire, be egress, and clearly identify the dditionally, NFPA 101, Life .3 states that existing life safety the public, if not required by ther maintained or removed. ice could affect kitchen staff on and interview with the nance at 2:09 p.m. on 03/20/25, tation" was mounted 62 inches to the door leading out of the nterview at 2:09 p.m., the nance acknowledged the asured with a tape measure. viewed with the Administrator intenance at the exit	TAG	of correction as opposed to a survey visit. We are willing to submit any and all document as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby providing our plan of correction the submission of this plan of correction does not constitute admission or an agreement be provider of the truth of facts alleged or corrections set for the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept plan of correction as our crecallegation of compliance. We requesting desk review for compliance. #1 On 03/20/2025, immediately the deficiency was observed, facility's Director of Maintenna initiated corrective action by contacting the licensed fire suppression vendor to relocated and the kitchen exit. The device we removed and reinstalled at 4 inches above the finished flocompliance with applicable correquirements. #2 The Director of Maintenance completed a facility-wide inspection of all ANSUL and manual fire system pull station.	ation wing on. of e an oy the th on red d this ditable are after the nce te the ear vas 8 or, in ode

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPI A. BUILDIN	LE CONSTRUCTION IG 01	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155153	B. WING	03/20/2025		
	PROVIDER OR SUPPLIE		205	EET ADDRESS, CITY, STATE, ZIP COD 531 DARDEN RD UTH BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROPR	DATE No d to of d y ards,	
14.00.45				accessibility. Any future installation or repositioning of fire suppress equipment must be verified by licensed vendor and double-checked by the Direct Maintenance. #4 The Director of Maintenance conduct annual inspections to verify the correct placement of fire suppression manual activatevices. Compliance will be included facility's annual Life Safety reand presented to the Safety Committee and QAPI meeting If any devices are found to be of compliance, corrective act will be taken within 24 hours.	ion by the tor of will oo of all vation in the eview gs. e out	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Based on record re	m - Testing and view and interview, the facility	K 0345	K345	04/23/2025	

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155153	ľ í	UILDING	onstruction 01	(X3) DATE : COMPL 03/20/	ETED
	OF PROVIDER OR SUPPLIEI			20531 [ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	accordance with NI Code as required by 9.6. NFPA 72, Sec otherwise permitted shall be performed schedules in Table by the authority has states that the followinspected semi-announced and the states that the following that the following that the states that the following that the states that the following that the states that the following that the following that the states that the following that the following that the states that the following the following that the following that the following	ble signals ators s (e.g. duct detectors, manual cat detectors, smoke detectors, iances pen devices ice could affect all residents, view and interview with the Director of Maintenance at 0/25, no documentation could be a visual semi-annual fire alarm At 11:53 a.m., during record r of Maintenance stated: "I			We here at the facility are respectfully requesting this agency consider paper compliance for the following p of correction as opposed to a survey visit. We are willing to submit any and all documenta as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby providing our plan of correction The submission of this plan of correction does not constitute admission or an agreement by provider of the truth of facts alleged or corrections set forth the statement because of deficiencies. This was prepare and submitted because of requirements under State and Federal Law. Please accept the plan of correction as our crediction allegation of compliance. We requesting desk review for compliance. #1 While no residents were directly affected by this deficient practical the lack of documentation for semi-annual visual inspection posed a potential risk to reside safety in the event of a fire emergency. Immediate contact was made with the facility's fir alarm vendor, and the semi-an report was requested #2 All residents have the potential be affected by this deficient	post tion ving n. an the n on ed his table are tty ice, the ent et ennual	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			
		155153	B. WING		03/20/2025	
	PROVIDER OR SUPPLIER		20531 [ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
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TAG	•	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
				practice. Therefore, the Direct Maintenance conducted a comprehensive review of fire is protocols and inspection schedules to ensure complian with all NFPA 101 Life Safety Code requirements. #3 The facility has contracted with the fire alarm vendor to ensure semi-annual visual inspections completed and documented in timely manner. Fire Safety Compliance will be tracked via TELS along with a safety inspections, including didates and documentation requirements. An automated calendar remine in TELS has been established alert the Maintenance Departrand Administrator of all upcomifie safety inspection deadlines. #4 The Administrator or designed audit for Fire Safety Complian semi-annually for one year to ensure timely completion and proper filing of all inspection reports. Results of the audits will be reviewed during the facility's monthly Quality Assurance an Performance Improvement (Questings. Any non-compliance identified result in immediate corrective action and re-education.	ce h e s are a e Il life ue der to ment ning s. e will ce d API)	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/20/2025 155153 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 20531 DARDEN RD **HEALTHWIN HEALTH & REHABILITATION** SOUTH BEND, IN 46637 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0511 NFPA 101 SS=E Utilities - Gas and Electric Bldg. 01 Based on observation and interview, the facility K 0511 K511 04/23/2025 failed to ensure all electrical panels in the We here at the facility are corridors were secured from non-authorized respectfully requesting this personnel. NFPA 70, 2011 edition states 230.62 agency consider paper Energized parts of service equipment shall be compliance for the following plan enclosed as specified in 230.62(A) or guarded as of correction as opposed to a post specified in 230.62(B). survey visit. We are willing to (A) Enclosed. Energized parts shall be enclosed submit any and all documentation so that they will not be exposed to accidental as requested to assure our contact or shall be guarded as in 230.62(B). credible compliance with the (B) Guarded. Energized parts that are not enclosed deficiencies noted in the following shall be installed on a switchboard, panelboard, or CMS-2567. We are hereby control board and guarded in accordance with providing our plan of correction. 110.18 and 110.27. Where energized parts are The submission of this plan of guarded as provided in 110.27(A)(1) and (A)(2), a correction does not constitute an means for locking or sealing doors providing admission or an agreement by the access to energized parts shall be provided. This provider of the truth of facts deficient practice could affect residents, staff and alleged or corrections set forth on visitors in the Northwest hall. the statement because of deficiencies. This was prepared Findings include: and submitted because of requirements under State and Based on observation and interview with the Federal Law. Please accept this Director of Maintenance at 2:53 p.m. on 03/20/25, plan of correction as our creditable an electrical panel in the Northwest Hall was allegation of compliance. We are partially open and unlocked when tested. Based requesting desk review for on interview at 2:53 p.m., at the time of compliance. observation, the Director of Maintenance acknowledged the electrical panel was unlocked On 03/20/2025, immediately after and stated, "I seen you just pull it open.". the deficiency was observed, the electrical panel located in the This finding was reviewed with the Administrator Northwest Hall was secured and and Director of Maintenance at the exit locked by the Director of conference. Maintenance. No residents or unauthorized staff had access to 3.1-19(b) the panel at the time of the survey, and no harm occurred.

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155153	B. WING 03/20/2025				
NAME OF D	DOWNER OF CURRINE		•	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			20531	DARDEN RD		
HEALTH	WIN HEALTH & RE	HABILITATION		SOUTH	H BEND, IN 46637		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE	
					#2		
					A complete facility audit of all electrical panels was conducted	ad	
					by the Director of Maintenance	l l	
					ensure each:	5 10	
					Is properly secured/lock	ed	
					Has no damage or acce		
					issues,		
					Is labeled and compliant	1	
					with NFPA 70		
					No additional unsecured pane	ls	
					were identified.		
					#3		
					All maintenance staff were		
					retrained on the requirement t keep all electrical panels secu		
					at all times, per NEC and Life	ieu	
					Safety Code standards.		
					A Preventive Maintenance		
					checklist was revised to include	de	
					monthly inspections of all		
					electrical panels to ensure each	ch is	
					closed, locked, and in proper		
					condition.		
					Any panel work now requires		
					completion of a lockout-tagour		
					(LOTO) form and signoff to co	l l	
					the panel is re-secured when	the	
					job is complete.		
					#4 The Director of Maintenance	, dill	
					The Director of Maintenance v		
					conduct monthly spot checks all electrical panels for 6 mont		
					and then quarterly thereafter.	113	
					Findings will be reviewed duri	na	
					the monthly QAPI and Safety	'8	
					Committee meetings.		
					Any noncompliant findings wil	l be	
					corrected immediately and		

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		155153	B. WI	2025			
NAME OF PROVIDER OR SUPPLIER HEALTHWIN HEALTH & REHABILITATION		•	20531 I	ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637	•		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	documented		DATE
K 0918 SS=F Bldg. 01	Based on observ	vation, record review and	K 09	918	K918 We here at the facility are		04/23/2025
	1. Based on observation, record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all				We here at the facility are respectfully requesting this agency consider paper compliance for the following profession of correction as opposed to a survey visit. We are willing to submit any and all documenta as requested to assure our credible compliance with the deficiencies noted in the follow CMS-2567. We are hereby providing our plan of correction The submission of this plan of correction does not constitute admission or an agreement by provider of the truth of facts alleged or corrections set forth the statement because of deficiencies. This was prepare and submitted because of requirements under State and Federal Law. Please accept the plan of correction as our credicallegation of compliance. We are requesting desk review for compliance.	post tion ving n. an vithe n on ed his table	0 1/23/2023
	Findings include: Based on record re	view and interview with the			Load Testing: The facility immediately initiate load bank test for the 600-kW	ed a	
	Based on record review and interview with the Administrator and Director of Maintenance at 11:58 a.m. on 03/20/25, the documented load information on monthly load tests of the 600-kW diesel generator load percentage for the				diesel generator to ensure tha runs at 30% or greater of its racapacity. The test is scheduled completion. The test results we	ated d for	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPL			ETED	
		155153	B. W	ING		03/20	/2025
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					DARDEN RD		
HEALTH	WIN HEALTH & RE	EHABILITATION		SOUTH	I BEND, IN 46637		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	diesel-powered gen	erator indicated the generator			be documented and filed for		
	was operated at less	s than 30 percent. Based on			review.		
	observation at 2:15	p.m. a 600-kW diesel generator			Fuel Quality Testing:		
	was observed in the	e rear of the facility. Based on			The facility contracted with a		
	interview at 11:58 a	a.m., the Director of			certified vendor to conduct a f	uel	
	Maintenance ackno	wledged the generator ran			quality test on the diesel fuel f	or	
	under load on a wee	ekly basis but did not achieve			the generator. The test is		
		plate rating. Additionally, the			scheduled for completion and	the	
	_	nance stated the facility is			results will be documented an		
	working to add the	load bank test to the contract			filed. Future fuel quality tests v	will	
	for services.				be scheduled annually in T as		
					of the generator service contra	•	
	2. Based on record	review and interview, the			36-Month Continuous 4-Hou		
	facility failed to ens	sure an annual fuel quality test			Test:		
	was performed for	the facility's diesel-powered			The facility has scheduled the		
	_	9, Health Care Facilities Code,			required 36-month continuous		
	2012 Edition Section	on 6.5.4.1.1.2 states Type 2 EES			4-hour test on the diesel		
	(Essential Electrica	l System) generator sets shall			generator. The documentatio	n	
	be inspected and te	sted in accordance with			was compiled and filed for rev	iew.	
	Section 6.4.4.1.1.3.	Section 6.4.4.1.1.3 states			The test will be conducted und	der	
	maintenance shall b	be performed in accordance			full load conditions, as require	d by	
	with NFPA 110, St	andard for Emergency and			regulations.		
	Standby Power Sys	stems, 2010 Edition, Chapter 8.			#2		
	NFPA 110, Section	8.3.8 states a fuel quality test			A full audit of all emergency p	ower	
	shall be performed	at least annually using tests			systems was conducted, inclu	ding	
	approved by ASTM	I standards. This deficient			the review of load testing		
	practice could affect	et all residents, staff, and			documentation, fuel quality		
	visitors.				records, and past generator te	est	
					logs. The audit confirmed that		
	Findings include:				there were no other deficienci	es	
					with the facility's emergency		
	Based on record review and interview with the				power systems, and corrective	е	
		Director of Maintenance at			actions were promptly taken for	or all	
		0/25, no documentation of an			findings.		
		test for the diesel generator			#3		
		eview. Based on observation at			Generator Service Contract		
	2:15 p.m. a 600-kW	V diesel generator was observed			Revision:		
		cility. Based on interview at			The facility has reviewed its		
	11:58 a.m., the Dire	ector of Maintenance			generator service contract to		
	acknowledged no d	acknowledged no documentation of an annual			include the annual fuel quality		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLE			ETED
		155153	B. W	ING		03/20	/2025
				_	_		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					DARDEN RD		
HEALTH	WIN HEALTH & RE	EHABILITATION		SOUTH	I BEND, IN 46637		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	fuel quality test was	s available and stated the			testing and quarterly load ban	k	
	facility is working	to add the test to the contract			testing to ensure the generato	r	
	for services.				consistently meets the minimu	ım	
					required load. These tests will	be	
	3. Based on observ	vation, record review and			performed on a regular sched	ule,	
	interview, the facili	ty failed to document 36-month			and results will be documente		
	period emergency g	generator testing for 1 of 1			and filed.		
	emergency generate	ors in accordance with NFPA			Scheduled Maintenance &		
	99 and NFPA 110.	NFPA 99, Health Care Facilities			Testing:		
	Code, 2012 Edition	, Section 6.4.1.1.6.1 states Type			The Preventive Maintenance I	Plan	
	1 and Type 2 essen	tial electrical system power			has been updated in TELS to		
	sources (EPSS) sha	ll be classified as Type 10,			include a schedule for monthly	y	
	Class X, Level 1 ge	enerator sets per NFPA 110.			generator checks, quarterly lo	ad	
	NFPA 110, the Star	ndard for Emergency and			testing, and annual fuel quality	y	
	Standby Powers Sy	stems, 2010 Edition, Section			tests. The facility will also ens	ure	
	8.4.9 states Level 1	EPSS shall be tested at least			that a 4-hour continuous test i	s	
	once within every 3	36 months. Section 8.4.9.1			conducted every 36 months as	s	
	states Level 1 EPSS	S shall be tested continuously			required by the Life Safety Co	de.	
	for the duration of i	its assigned class (See Section			Training and Documentation	ı:	
	4.2). Section 8.4.9.	.2 states where the assigned			All maintenance staff will be		
	class is greater than	4 hours, it shall be permitted			retrained on the requirements	for	
	to terminate the test	t after 4 continuous hours.			generator load testing, fuel qu	ality	
	Section 8.4.9.5 state	es the minimum load for this			testing, and documentation		
	test shall be specific	ed in 8.4.9.5.1, 8.4.9.5.2, or			practices. Additionally, the		
	8.4.9.5.3. Section 8	8.4.9.5.3 states for spark-ignited			Director of Maintenance will		
	_	l be the available EPSS load.			oversee the proper filing and		
	This deficient pract	ice could affect all residents,			tracking of all test results.		
	staff, and visitors.				#4		
					The Director of Maintenance v	will	
	Findings include:				implement a monthly review o	f all	
					generator service and test		
	Based on record rev	view and interview with the			documentation, ensuring that	all	
		Director of Maintenance at			required tests and maintenand	ce	
	_	0/25, thirty-six-month period			are completed and properly fil	ed.	
		or testing documentation for			The facility's Quality Assurance	e	
	four continuous hor	urs for the diesel fired			and Performance Improvemer	nt	
	emergency generate	or was not available for review.			(QAPI) Committee will review		
		on with the Director of			generator testing logs during		
	Maintenance at 2:1	5 p.m. a 600-kW diesel			monthly meetings for the next	6	
	generator was obse	rved in the rear of the facility.	1		months to verify compliance w	vith	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING O3/20/20			ETED		
NAME OF PROVIDER OR SUPPLIER HEALTHWIN HEALTH & REHABILITATION			20531 [ADDRESS, CITY, STATE, ZIP COD DARDEN RD I BEND, IN 46637			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Maintenance ackno was available to sho generator in the last facility is working t contract for services. These findings were	•			required schedules. Any future missed or incomple testing will be addressed withi hours, and corrective action w documented.	n 24	

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