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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN HEALTH & REHABILITATION	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: 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 plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance.	
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 plan of correction as opposed to a post	04/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bud Johnson	Administrator	04/09/2025

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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	exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 11:26 a.m. on 03/20/25, the facility was unable to provide documentation of any exercises of the EPP conducted during the past 12-month period. At 11:26 a.m., the Administrator stated he did not have documentation of any exercises conducted		survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** The facility immediately reviewed the Emergency Preparedness Training and Testing program upon identification of the deficiency. Staff identified as not having received the required emergency preparedness training were immediately scheduled for and completed updated training, including documentation of completion. **#2** All current residents have the potential to be affected by inadequate staff training and testing procedures. A facility-wide audit was conducted to determine staff compliance with emergency	

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	in the past 12 months, however, he has planned to conduct exercises soon. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference.		preparedness training requirements. No residents were found to have been directly harmed. **#3** The Emergency Preparedness Coordinator will maintain a training log and ensure all staff receive initial and annual emergency preparedness training. A tracking system will be implemented to monitor due dates for training and drill participation. The facility will conduct at least two emergency drills per year (one being full-scale), and staff participation will be documented and reviewed for compliance. **#4** The Administrator or designee will audit training records monthly for six months to ensure 100% compliance. Results will be reported and reviewed at monthly QAPI meetings. Any instances of noncompliance will be addressed immediately with re-education and corrective action.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power 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	E 0041	**E041** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post	04/23/2025

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	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 residents, staff, and visitors. Findings include: 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-powered generator indicated the generator was operated at less than 30 percent. Based on observation at 2:15 p.m. a 600-kW diesel generator was observed in the rear of the facility. Based on interview at 11:58 a.m., the Director of Maintenance acknowledged the generator ran under load on a weekly basis but did not achieve 30 % of the name plate rating. Additionally, the Director of Maintenance stated the facility is working to add the load bank test to the contract for services.		survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Upon identification of the deficiency, the facility's emergency generator system was scheduled to be inspected by a licensed contractor to ensure full operational status. Any maintenance issues were resolved, and a full test of the generator under load was successfully completed. No residents were harmed as a result of the deficiency. **#2** All residents have the potential to be affected by deficiencies in the emergency power system. A facility-wide risk assessment was	

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	2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 11:58 a.m. on 03/20/25, no documentation of an annual fuel quality test for the diesel generator was available for review. Based on observation at 2:15 p.m. a 600-kW diesel generator was observed in the rear of the facility. Based on interview at 11:58 a.m., the Director of Maintenance acknowledged no documentation of an annual fuel quality test was available and stated the facility is working to add the test to the contract for services. 3. Based on observation, record review, and interview, the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power		conducted, and emergency power coverage for all critical systems was verified and no residents were harmed. **#3** The facility has contracted with a certified electrical provider for monthly generator inspections and annual full-load testing in accordance with NFPA 110 and CMS requirements. A preventative maintenance schedule has been developed and added to the facility's emergency preparedness binder. Backup logs for generator testing (weekly, monthly, and annual) will now be reviewed monthly in TELS 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 issues will be addressed within 24 hours and corrective action documented. Findings will be reviewed during monthly QAPI meetings and included in the Emergency Preparedness annual review	

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	sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 12:03 p.m. on 03/20/25, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on observation with the Director of Maintenance at 2:15 p.m. a 600-kW diesel generator was observed in the rear of the facility. Based on interview at 11:58 a.m., the Director of Maintenance acknowledged no documentation was available to show a 4-hour test of the generator in the last 36 months and stated the facility is working to add the load bank test to the contract for services. These findings were reviewed with the Administrator and Director of Maintenance at the exit conference.			

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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: 03/20/2025 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Life Safety Code survey, Healthwin Health & Rehabilitation was found not in 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 98 at the time of this survey. Quality Review conducted on 03/24/25	K 0000	**K0000** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance.	

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of more than 10 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect residents, staff and visitors in the West hall. Findings include: Based on observation and interview with the Director of Maintenance at 12:39 p.m. on 03/20/25, the exit door from the 1st floor West Hall next to resident room 155 was magnetically locked requiring a code, but the code was not posted at the exit. At 12:39 p.m., the Director of Maintenance stated the code was posted on the keypad but it had been removed without his knowledge. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)	K 0222	**K222** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** On 03/20/2025, immediately following the surveyor's observation, the facility re-posted the correct keypad exit code on the magnetic lock located next to Room 155 on the 1st Floor West Hall. The code was placed in clear, visible signage directly above the keypad, in accordance	04/23/2025

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			with NFPA Life Safety Code requirements. **#2** The Maintenance Director completed a facility-wide audit of all egress doors equipped with magnetic locks requiring a keypad or code. All such doors were reviewed to ensure that: Required codes are visibly posted, Doors are functioning in a manner compliant with safe egress requirements, and No other exits were similarly deficient. No additional issues were identified during the audit. **#3** A Preventive Maintenance Checklist has been updated to include monthly visual inspections of all exit doors with keypad or magnetic locking mechanisms. The Maintenance Department has been retrained on Life Safety Code egress requirements, particularly regarding: Proper signage for locked exits, The importance of unrestricted means of egress unless allowed under special provisions. Any changes to door locking systems must now be reviewed by the Safety Committee and	

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			#4 The Maintenance Director will conduct monthly audits for 6 months to verify that: ·All egress codes remain clearly posted, ·Magnetic locking systems function properly, ·Staff are familiar with egress procedures. Results will be reviewed during monthly QAPI and Safety Committee meetings.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 4 of 12 egress discharge paths were marked with directional signage. LSC 7.7.3.2 states the exit discharge shall be arranged and marked to make clear the direction of egress travel from the exit discharge to a public way. This deficient practice could affect residents, staff and visitors in 4 of 7 smoke compartments. Findings include: Based on observation and interview with the Director of Maintenance on 03/20/25, a fenced courtyard with a gate that discharged to a public way was not marked to make clear the direction of egress travel. The walkway to the exit discharge was connected to several other walkways. A gate at the end of the exit discharge from the courtyard was located on the west end of the building and was not visible from any exit of the building. The following exits from the building all discharged into the courtyard and were not marked to make	K 0271	**K271** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and	04/23/2025

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	clear the direction of travel to a public way: 1. At 12:43 p.m. the exit from the 1st floor West Hall next to resident room 155 was observed. This was acknowledged by the Director of Maintenance at 12:43 p.m. 2. At 12:43 p.m. the exit from the hall leading to the front lobby smoke compartment was observed. This was acknowledged by the Director of Maintenance at 12:43 p.m. 3. At 1:18 p.m. the exit from the business hall to the courtyard was observed. This was acknowledged by the Director of Maintenance at 1:18 p.m. 4. At 1:31 p.m. the exit from the Therapy lounge was observed. This was acknowledged by the Director of Maintenance at 1:31 p.m. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Immediately following the survey, the facility installed permanent directional signage within the fenced courtyard, clearly indicating the path to the public way from all courtyard exits. Signs were placed at: The exit near Room 155 (West Hall), The hallway leading to the front lobby smoke compartment, The business hallway exit, The Therapy Lounge exit. All exit signage is mounted at eye level, consistent with NFPA 101 Life Safety Code standards. **#2** A full facility walk-through was conducted by the Maintenance Director and Administrator to identify any other exits or discharge areas that may lack appropriate directional signage. All other exit discharge areas were verified as clearly marked or updated with signage as needed to ensure proper egress during an emergency. **#3** A Life Safety Signage Checklist has been created and will be used quarterly to verify the presence and visibility of all directional egress signage, especially for	

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			outdoor discharge paths. All maintenance staff have been retrained on the requirements for marking exit routes under NFPA 101. All new construction or changes to landscaping or pathways that could affect egress visibility will require a Life Safety compliance review prior to implementation. **#4** The Maintenance Director will complete quarterly audits for one year to confirm signage remains intact, visible, and appropriately located. The results of each audit will be reported at the monthly QAPI and Safety Committee meetings. Any missing, damaged, or blocked signs will be corrected within 24 hours and logged in the maintenance report.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure continuity of egress lighting for 4 of 12 exits. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect residents, staff and visitors in 4 of 7 smoke compartments. Finding include: Based on observation and interview with the Director of Maintenance at 12:43 p.m. on 03/20/25,	K 0281	**K281** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction.	04/23/2025

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	03/20/2025

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

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	the exit discharge sidewalks from exit doors from the West Hall, the connecting hall to the front lobby hall, the business hall and the Therapy lounge, did not have egress lighting for portions of the sidewalks from the exit to the public way. Based on interview at 1:31 p.m., the Director of Maintenance confirmed there were no other lighting devices illuminating the sidewalks and acknowledged the lighting at the exit doors did not illuminate the entire egress discharge to a public way. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Immediately following the 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. **#2** 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	

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	03/20/2025

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

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			deficient at the time of the audit. **#3** New permanent outdoor lighting fixtures have been ordered and scheduled for installation along the affected discharge sidewalks. These fixtures will provide continuous illumination, meeting the required minimum of 1 foot-candle, and will be tied into the facility's emergency backup power system. The Maintenance Department has been retrained on NFPA 101 requirements for continuous egress lighting. **#4** The Director of Maintenance or designee will conduct quarterly nighttime inspections of all exterior egress routes to ensure lighting is functional and fully illuminating all exit pathways to the public way. Results of inspections will be presented at monthly QAPI and Safety Committee meetings. Any outages or failures will be addressed immediately, with a maximum 24-hour turnaround for repair or replacement.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A	K 0324	**K324** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan	04/23/2025

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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	readily accessible means for manual activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Director of Maintenance at 2:09 p.m. on 03/20/25, the ANSUL "Pull Station" was mounted 62 inches above the floor next to the door leading out of the kitchen. Based on interview at 2:09 p.m., the Director of Maintenance acknowledged the measurement as measured with a tape measure. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** On 03/20/2025, immediately after the deficiency was observed, the facility's Director of Maintenance initiated corrective action by contacting the licensed fire suppression vendor to relocate the ANSUL pull station located near the kitchen exit. The device was removed and reinstalled at 48 inches above the finished floor, in compliance with applicable code requirements. **#2** The Director of Maintenance completed a facility-wide inspection of all ANSUL and manual fire system pull stations to	

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	03/20/2025

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

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			verify their mounting height. No other pull stations were found to be out of compliance. A log of each measurement was maintained for records. **#3** The Preventive Maintenance checklist has been updated to include annual verification of manual fire suppression pull station placement and height. All maintenance staff received retraining on NFPA fire safety equipment installation standards, specifically regarding height and accessibility. Any future installation or repositioning of fire suppression equipment must be verified by the licensed vendor and double-checked by the Director of Maintenance. **#4** The Director of Maintenance will conduct annual inspections to verify the correct placement of all fire suppression manual activation devices. Compliance will be included in the facility's annual Life Safety review and presented to the Safety Committee and QAPI meetings. If any devices are found to be out of compliance, corrective action will be taken within 24 hours.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility	K 0345	**K345**	04/23/2025

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	03/20/2025

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

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	failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 11:53 a.m. on 03/20/25, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. At 11:53 a.m., during record review, the Director of Maintenance stated: "I don't think I have it.". This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** While no residents were directly affected by this deficient practice, the lack of documentation for the semi-annual visual inspection posed a potential risk to resident safety in the event of a fire emergency. Immediate contact was made with the facility's fire alarm vendor, and the semi-annual report was requested **#2** All residents have the potential to be affected by this deficient	

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	155153	A. BUILDING 01 B. WING	03/20/2025

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

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			practice. Therefore, the Director of Maintenance conducted a comprehensive review of fire safety protocols and inspection schedules to ensure compliance with all NFPA 101 Life Safety Code requirements. **#3** The facility has contracted with the fire alarm vendor to ensure semi-annual visual inspections are completed and documented in a timely manner. Fire Safety Compliance will be tracked via TELS along with all life safety inspections, including due dates and documentation requirements. An automated calendar reminder in TELS has been established to alert the Maintenance Department and Administrator of all upcoming life safety inspection deadlines. **#4** The Administrator or designee will audit for Fire Safety Compliance 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 and Performance Improvement (QAPI) meetings. Any non-compliance identified will result in immediate corrective action and re-education.	

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	155153	A. BUILDING 01 B. WING	03/20/2025

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

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were 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 residents, staff and visitors in the Northwest hall. Findings include: Based on observation and interview with the Director of Maintenance at 2:53 p.m. on 03/20/25, an electrical panel in the Northwest Hall was partially open and unlocked when tested. Based on interview at 2:53 p.m., at the time of observation, the Director of Maintenance acknowledged the electrical panel was unlocked and stated, "I seen you just pull it open.". This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)	K 0511	**K511** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** On 03/20/2025, immediately after the deficiency was observed, the electrical panel located in the Northwest Hall was secured and locked by the Director of Maintenance. No residents or unauthorized staff had access to the panel at the time of the survey, and no harm occurred.	04/23/2025

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	03/20/2025

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

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			#2 A complete facility audit of all electrical panels was conducted by the Director of Maintenance to ensure each: Is properly secured/locked, Has no damage or access issues, Is labeled and compliant with NFPA 70 No additional unsecured panels were identified. **#3** All maintenance staff were retrained on the requirement to keep all electrical panels secured at all times, per NEC and Life Safety Code standards. A Preventive Maintenance checklist was revised to include monthly inspections of all electrical panels to ensure each is closed, locked, and in proper condition. Any panel work now requires completion of a lockout-tagout (LOTO) form and signoff to confirm the panel is re-secured when the job is complete. **#4** The Director of Maintenance will conduct monthly spot checks of all electrical panels for 6 months and then quarterly thereafter. Findings will be reviewed during the monthly QAPI and Safety Committee meetings. Any noncompliant findings will be corrected immediately and	

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	03/20/2025

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

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			documented	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 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 residents, staff, and visitors. Findings include: 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	K 0918	**K918** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. The submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because of deficiencies. This was prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** **Load Testing:** The facility immediately initiated a load bank test for the 600-kW diesel generator to ensure that it runs at 30% or greater of its rated capacity. The test is scheduled for completion. The test results will	04/23/2025

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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN HEALTH & REHABILITATION	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
	diesel-powered generator indicated the generator was operated at less than 30 percent. Based on observation at 2:15 p.m. a 600-kW diesel generator was observed in the rear of the facility. Based on interview at 11:58 a.m., the Director of Maintenance acknowledged the generator ran under load on a weekly basis but did not achieve 30 % of the name plate rating. Additionally, the Director of Maintenance stated the facility is working to add the load bank test to the contract for services. 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 11:58 a.m. on 03/20/25, no documentation of an annual fuel quality test for the diesel generator was available for review. Based on observation at 2:15 p.m. a 600-kW diesel generator was observed in the rear of the facility. Based on interview at 11:58 a.m., the Director of Maintenance acknowledged no documentation of an annual		be documented and filed for review. **Fuel Quality Testing:** The facility contracted with a certified vendor to conduct a fuel quality test on the diesel fuel for the generator. The test is scheduled for completion and the results will be documented and filed. Future fuel quality tests will be scheduled annually in T as part of the generator service contract. **36-Month Continuous 4-Hour Test:** The facility has scheduled the required 36-month continuous 4-hour test on the diesel generator. The documentation was compiled and filed for review. The test will be conducted under full load conditions, as required by regulations. **#2** A full audit of all emergency power systems was conducted, including the review of load testing documentation, fuel quality records, and past generator test logs. The audit confirmed that there were no other deficiencies with the facility's emergency power systems, and corrective actions were promptly taken for all findings. **#3** **Generator Service Contract Revision:** The facility has reviewed its generator service contract to include the annual fuel quality	

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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN HEALTH & REHABILITATION	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
	fuel quality test was available and stated the facility is working to add the test to the contract for services. 3. Based on observation, record review and interview, the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 12:03 p.m. on 03/20/25, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on observation with the Director of Maintenance at 2:15 p.m. a 600-kW diesel generator was observed in the rear of the facility.		testing and quarterly load bank testing to ensure the generator consistently meets the minimum required load. These tests will be performed on a regular schedule, and results will be documented and filed. **Scheduled Maintenance & Testing:** The Preventive Maintenance Plan has been updated in TELS to include a schedule for monthly generator checks, quarterly load testing, and annual fuel quality tests. The facility will also ensure that a 4-hour continuous test is conducted every 36 months as required by the Life Safety Code. **Training and Documentation:** All maintenance staff will be retrained on the requirements for generator load testing, fuel quality testing, and documentation practices. Additionally, the Director of Maintenance will oversee the proper filing and tracking of all test results. **#4** The Director of Maintenance will implement a monthly review of all generator service and test documentation, ensuring that all required tests and maintenance are completed and properly filed. The facility's Quality Assurance and Performance Improvement (QAPI) Committee will review generator testing logs during monthly meetings for the next 6 months to verify compliance with	

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	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN HEALTH & REHABILITATION	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
	Based on interview at 11:58 a.m., the Director of Maintenance acknowledged no documentation was available to show a 4-hour test of the generator in the last 36 months and stated the facility is working to add the load bank test to the contract for services. These findings were reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		required schedules. Any future missed or incomplete testing will be addressed within 24 hours, and corrective action will be documented.	