DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	**INITIAL COMMENTS** This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00414031 and IN00410181 completed on 9/22/2023. Complaint IN00414031 - Corrected. Complaint IN00410181 - Corrected. Survey dates: December 5, 2023 Facility number: 000073 Provider number: 155153 AIM number: 100288820 Census Bed Type: SNF/NF: 109 SNF: 7 Total: 116 Census Payor Type: Medicare: 10 Medicaid: 67 Other: 39 Total: 116 Healthwin was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00414031 and IN00410181. Quality review completed 12/6/2023.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE