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	05/06/2025

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 03/20/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/06/25 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Emergency Preparedness survey, Healthwin was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 145 and had a census of 93 at the time of this survey. Quality Review completed on 05/07/25	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 03/20/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR Subpart 483.90(a). Survey Date: 05/06/25 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this Life Safety Code survey, Healthwin was	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Chalman	Interim Administrator	05/16/2025

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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	155153	A. BUILDING 01 B. WING	05/06/2025

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	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 93 at the time of this survey. Quality Review completed on 05/07/25			
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 with the Director of Maintenance at 11:04 a.m. on 05/06/2025, a fenced	K 0271	1 The facility will ensure the exit discharge is arranged and marked so as to make clear the direction of egress travel from the exit discharge to the public way. Four temporary exit signs have been placed at the four points of egress from the courtyard to the exit from the courtyard. Permanent signs were ordered May 9, 2025 and will be installed upon arrival. 2 All residents have the	05/23/2025

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	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 clear the direction of travel to a public way: 1. The exit from the 1st floor West Hall was observed next to resident room 155. 2. The exit from the hall leading to the front lobby smoke compartment. 3. The exit from the business hall to the courtyard. 4. The exit from the Therapy lounge. Based on interview with the Director of Maintenance at 10:01 a.m. on 05/06/2025, he stated exit signage was ordered but was not received by time of survey. This finding was reviewed with the Interim Administrator and Director of Maintenance at the exit conference. This deficiency was cited on 03/20/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		potential to be affected by this deficient practice. 3 Monthly the maintenance director will check the signage in the courtyard to assure proper placement. 4 The results of monthly maintenance checks will be reviewed in QAPI for the next four months.	
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	K 0281	1 1. The facility will ensure the means of egress for all designated exit discharges are provided with artificial lighting for such periods of time as necessary to maintain levels of illumination to a public	05/23/2025

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	deficient practice could affect residents, staff and visitors in 4 of 7 smoke compartments. Finding include: Based on observation with the Director of Maintenance at 11:05 a.m. on 05/06/2025, 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 with the Director of Maintenance at 10:02 a.m. on 05/06/2025 he stated the facility received a quote for lighting in the courtyard but the quote was too high and they haven't provided lighting in the path of egress through the courtyard by the time of survey. This finding was reviewed with the Interim Administrator and Director of Maintenance at the exit conference. This deficiency was cited on 03/20/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		way. Four solar lights were purchased on May 8, 2025 for the courtyard. Installation is scheduled for May 21, 2025. 2 2. All residents have the potential to be affected by this deficient practice. 3 3. Monthly the maintenance director will check the solar lights in the courtyard to assure they are in proper working order. 4 4. The results of the monthly maintenance checks will be reviewed in QAPI for the next four months.	