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 _____	R **06/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHWIN HEALTH & REHABILITATION	**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
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the PSR survey that exited on 05/06/2025 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 483.90(a). Survey Date: 06/05/2025 Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820 At this PSR, Healthwin was found 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 87 at the time of this survey. Quality Review completed on 06/09/25	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.