PRINTED: 04/22/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155153	(X2) MULTIPLE C A. BUILDING B. WING	03/27/2025		
	PROVIDER OR SUPPLIE		20531	ADDRESS, CITY, STATE, ZIP COD DARDEN RD H BEND, IN 46637		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF 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. 00	IN00456011.  Complaint IN0045 related to the alleg F684.  Survey dates: Mark Facility number: 0 Provider number: AIM number: 1000.  Census Bed Type: SNF/NF: 86 SNF: 8 Total: 94  Census Payor Typ Medicare: 5 Medicaid: 61 Other: 28 Total: 94  These deficiencies accordance with 4	155153 288820 e: reflect State Findings cited in	F 0000			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3)	ent Comprehensive Care Plan				
	failed to ensure a concluding a plan for	ov and record review, the facility comprehensive plan of care or type 2 diabetes, wound care e was created for 1 of 3	F 0656	F656 We here at the facility are respectfully requesting this agency consider paper compliance for the following p	04/30/2025 lan	
LABORATOF	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

Bud Johnson Administrator 04/10/2025

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

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 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QNZO11 Facility ID: 000073 If continuation sheet Page 1 of 6

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DEPARTMENT OF HEALTH AND HUM	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR MEDICARE & MEDICA	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	LETED	
	155153	B. WI	NG		03/27/	/2025
			1			
NAME OF PROVIDER OR SUPPLIER			STREET A			
WINE OF TROVIDER OR SOTTEIER			20531 E	DARDEN RD		
HEALTHWIN HEALTH & REHABILITATION			SOUTH BEND, IN 46637			
THE RETURN OF THE PROPERTY OF				,		

NAME OF PROVIDER OR SUPPLIER			20531 DARDEN RD			
	HEALTHWIN HEALTH & REHABILITATION SOUTH BEND, IN 46637					
ПЕАСІП	IVIIN HEALTH & REHABILITATION	30011	H BEND, IN 40037			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG		DATE		
	residents reviewed for care plans. (Resident B)		of correction as opposed to a post			
	Finding includes:		survey visit. We are willing to submit any and all documentation			
	I maing metades.		as requested to assure our			
	On 3/27/25 at 11:30 A.M., a clinical record review		credible compliance with the			
	was completed for Resident B's. Diagnoses		deficiencies noted in the following			
	included, but were not limited to, paraplegea, type		CMS-2567. We are hereby			
	2 diabetes, osteomylitis of the left femur that		providing our plan of correction.			
	required surgical intervention and the application		The submission of this plan of			
	of wound vac placement, colostomy status, and		correction does not constitute an			
	pressure ulcers.		admission or an agreement by the			
	TI A IM'' D ( C ( /MDC)		provider of the truth of facts			
	The Annual Minimum Data Set (MDS)		alleged or corrections set forth on			
	assessment,dated 2/21/25, indicated Resident B was fully cognitively intact, required extensive		the statement because of deficiencies. This was prepared			
	assistance for bed mobility, transferring, bathing,		and submitted because of			
	dressing, and personal hygiene. The resident was		requirements under State and			
	assessed to have had two stage 2 pressure ulcers,		Federal Law. Please accept this			
	one unstageable pressure ulcer, and a surgical		plan of correction as our creditable			
	wound. In addition, Resident B was receiving		allegation of compliance. We are			
	insulin for diabetes and had received 5 injections		requesting desk review for			
	in the previous 7 days.		compliance.			
	Physician's orders included the following:		#1			
	-Lantus Subcutaneous Solution to inject 10 units		Resident B care plan is unable to			
	at bedtime for type 2 diabetes, ordered 11/6/25 and		be updated as this resident no			
	discontinued on 3/6/23. There was no order for		longer resides at the facility. The			
	the treatment of low blood sugar.		facility has been conducting			
	-Wound vac to left ischium tuberosity (lower area		education through a prior			
	of the pelvis on the side of the buttock), connect		noncompliance facility review and			
	negative pressure wound treatment (NPWT)		will continue to monitor facility			
	system at 150mmHg. Change wound vac on		care plans for proper			
	Mondays and Fridays for wound care, ordered		documentation based off the			
	2/26/25.		individualized care plans for			
	-Ostomy care every shift, ordered 2/10/25		residents.			
	A review of Resident B's care plans indicated a		#2			
	lack of goals and interventions for low blood		All residents with diagnoses or treatments that include diabetes			
	sugar (hypoglycemia), wound vac care to address		type 2, wounds, and colostomy			
	the pressure ulcers and ostomy care.		care have the potential to be			
	and pressure areons and ostorny care.		oare nave the potential to be			

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Event ID:

QNZO11 Facility ID: 000073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155153	B. WI	ING		03/27/	2025
HEALTH	PROVIDER OR SUPPLIEF	HABILITATION	STREET ADDRESS, CITY, STATE, ZIP COD 20531 DARDEN RD SOUTH BEND, IN 46637				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY 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			DATE
TAG	On 3/27/25 at 9:05 provided an undated Planning-Comprehe indicating it was the policy indicated, " the resident's immer for each resident with admission'Baseling developed within 44 assure that the resident and maintained needed to provide each that meets professional provides at the provided as the provided are that meets professional provided as the provid	A.M., the Administrator dipolicy titled, "Care ensive Person-Centered," e current facility policy. The .A baseline care plan to meet diate needs shall be developed (thin forty-eight (48) hours of the Care Plan': is a care plan 8 hours of admission1. To dent's immediate care needs are l,bii. The instructions ffective and person-centered fessional standards of quality		TAG	affected by the alleged deficie practice. As a result, all care plans for residents currently undergoing treatment for diabet type 2, wounds, and colostom care were reviewed and update immediately.  #3  All staff members, including the innursing and interdisciplinary team roles, were re-educated the importance of timely and accurate updates to the comprehensive care plans and documentation of care provided This education was completed 4/7/2025 by Sirrena Miller, DC #4  To ensure the continued accur of care plans, the interdisciplinate team will conduct weekly audit resident care plans with diagnosis's that include diabet type 2, wounds, and colostom care for three months. Audits we completed by the Director of Nursing (DON) or designee 3	etes y ted ose on d ed. I on oN. aracy harry ts of	DATE
					times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks The QAPI committee will review audit resmonthly for the next three mor If no further concerns are identified, the monitoring procewill transition to quarterly audit issues persist, additional staff training and corrective actions be implemented promptly.	sults oths. ess ts. If	

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PRINTED: 04/22/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155153	B. WING		03/27/2025
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIER	8		DARDEN RD	
HEALTH	IWIN HEALTH & RE	EHABILITATION		H 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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0684	483.25				
SS=D	Quality of Care				
Bldg. 00					
-	Based on interview	and record review the facility	F 0684	F684	04/30/2025
	failed to ensure phy	vsician orders were in place for		We here at the facility are	
		v blood glucose, and failed to		respectfully requesting this	
		ntation was completed for		agency consider paper	
		ent according to physician		compliance for the following p	olan
		sidents reviewed for diabetic		of correction as opposed to a	
		ound treatment, (Resident B).		survey visit. We are willing to	·
	management and w	ound treatment, (Resident B).		submit any and all documenta	
	Finding includes:			as requested to assure our	111011
	Tilluling illerades.			I	
	On 2/27/25 at 11.20	A.M. a aliminal manand marriage		credible compliance with the	
		A.M., a clinical record review		deficiencies noted in the follow	wing
	_	Resident B's. Diagnoses		CMS-2567. We are hereby	
		type 2 diabetes, osteomylitis		providing our plan of correction	
		eizure disorder, history of		The submission of this plan of	
	1	tatus, neurogenic bladder		correction does not constitute	
		r, resistance to multiple		admission or an agreement by	y the
	antibiotics, tachycai	rdia, and pressure ulcers.		provider of the truth of facts	
				alleged or corrections set forth	n on
		um Data Set (MDS)		the statement because of	
	assessment dated 2/21/25, indicated Resident B was fully cognitively intact, required extensive assistance for bed mobility, transferring, bathing, dressing, and personal hygiene. The resident was assessed to have had two stage 2 pressure ulcers,			deficiencies. This was prepare	ed
				and submitted because of	
				requirements under State and	
				Federal Law. Please accept t	ihis
				plan of correction as our credi	
		essure ulcer, and a surgical		allegation of compliance. We	are
	wound. In addition	, Resident B was receiving		requesting desk review for	
	insulin for diabetes	and had received 5 injections		compliance.	
	in the previous 7 da	ays.		#1	
				Resident B is no longer a resi	dent
	Physician's orders is	ncluded the following:		at the facility. Based on past	
	-Lantus Subcutaneo	ous Solution to inject 10 units		noncompliance the facility is	
	at bedtime for type	2 diabetes, ordered 11/6/25 and		currently reviewing document	ation
	discontinued on 3/6	5/23. There were no orders in		of care provided to residents.	
	place for the treatm	ent of low blood sugar.		#2	
	-	ntment 250 Unit/GM, to apply		All residents have the potentia	al to
	· ·	ally one time daily for eschar,		be affected by the alleged def	
		nguinoes draining, ordered		practice. The facility will ensur	

practice. The facility will ensure

PRINTED: 04/22/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING AND PLAN OF CORRECTION COMPLETED 155153 R WING 03/27/2025

	155153	B. WING		03/27/2025
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	While of TROVIDER OR SOFTEEN		DARDEN RD	
HEALTH	IWIN HEALTH & REHABILITATION	SOUTH	H BEND, IN 46637	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	2/18/25.		that all residents with physician	n
	-Ostomy care every shift, ordered 2/10/25.		orders for insulin, wound vacs	and
			ostomy care have the proper	
	Review of Resident B's February and March 2025		documentation supporting the	
	Medication Administration Records and		treatments provided to residen	ts in
	Treatment Administration Records indicated a		our care. A house wide audit o	f
	lack of documentation for the administration of		residents receiving insulin, hav	∕e a
	Santyl External Ointment 250 Unit/GM, to apply to		wound vac and/or ostomy care	)
	the coccyx topically one time daily on 2/22/25,		was conducted on 4/7/2025 ar	
	2/23/25, and 3/6/25.		all orders, care plans have bee	en
	There was also a lack of documentation for		updated to include proper requ	iired
	ostomy care on 2/18/25 on the night shift and on		supporting documentation as	
	3/3/25 on the day shift.		indicated per our policies. Aud	
			were conducted by Sirrena Mil	ler,
	During an interview on 3/26/25 at 4:30 P.M., the		DON	
	Director of Nursing (DON), indicated there was		#3	
	not a physician's order for hypoglycemic care and		All nursing staff will be educate	
	some documentation related to Resident B's		on following physician orders a	
	wound and ostomy care was missing.		documenting the application of	f
			prescribed treatments for	
	On 3/27/25 at 9:05 A.M., the Administrator		residents that have insulin, wo	und
	provided a policy dated 10/1/21, titled, "Diabetes		vacs and ostomy care This	
	Mellitus - Nursing Care Of The Older Adult,"		education will be completed or	n or
	indicating it was the current facility policy. The		before 4/15/2025 by the	
	policy indicated, "Unless a physician has		DON/designee.	
	ordered specific parameters for monitoring,		#4	
	treating, and notifying the physician of blood		Audits will be completed by the	9
	sugar levels, the facility's routine standing orders		Director of Nursing (DON) or	,
	will be used"		designee 3 times per week for	4
	On 2/27/25 at 0.05 A M at - A decision decrease		weeks, 2 times per week for 4	
	On 3/27/25 at 9:05 A.M., the Administrator		weeks, weekly for 4 weeks on	
	provided an undated policy titled, "Documentation Of Wound Treatments,"		varying shifts to ensure insulin	
	indicating it was the current facility policy. The		wound vacs and ostomy care a	ale
	policy indicated, "Wound assessments are		being documented per facility	uill
	documented at the time of each treatment"		policy. The Director of Nursing	WIII
	documented at the time of each treatment		review the audits, and any	ith
	This citation relates to Complaint IN100456011		deviations will be addressed w	
	This citation relates to Complaint IN00456011.		immediate retraining. The QAF	1

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3.1-37(a)

Event ID:

QNZO11

Facility ID: 000073

If continuation sheet

committee will review audit results

monthly for three months to

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/22/2025 FORM APPROVED 0. 0938-039

ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED
	155153	R WING	03/27/2025

	OF CORRECTION	IDENTIFICATION NUMBER  155153	A. BUILDING B. WING	00	COMPLETED 03/27/2025
	NAME OF PROVIDER OR SUPPLIER  HEALTHWIN HEALTH & REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP COD 20531 DARDEN RD SOUTH BEND, IN 46637				
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				ensure compliance. If no concer arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, v be implemented.	

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