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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation interview, and record review, the facility failed to serve food at a palatable temperature for 1 of 4 nursing units. (West unit) This potentially affected 20 of 86 residents who ate food prepared in the kitchen. During an observation and temperature check of supper trays from a covered food cart, on the [NAME] 2 unit, on 4/21/2026 at 6:02 P.M., food was not served at a palatable temperature and the following temperatures were obtained:-the pureed grilled cheese was served at 125 degrees Fahrenheit.-the mashed potatoes and gravy was served at 128 degrees Fahrenheit.During an interview on 4/21/2026 at 6:02 P.M., the Dietary Director indicated the food should have been 135 degrees (Fahrenheit) at the point of service.On 4/22/2026 at 3:00 P.M. an undated policy titled, Food Preparation and Service was provided by the DON. The policy indicated, .potentially hazardous food must be maintained below 41 degrees or above 135 degrees 410 IAC 16.2-3.1-21(a)(2)

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.

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

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, the facility failed to prepare and serve food in a sanitary manner for 1 of 1 kitchens. This deficient practice potentially affected 82 out 86 residents who ate food prepared in the kitchen. During an initial tour and observation of the kitchen on 4/15/2026 at 9:42 A.M. with the Dietary Director (DD) the following was noted:-a bag of frozen chicken strips and french fries were in the reach-in freezer opened and unsealed.-a baking tray put away as clean had bottom part of the tray covered in a brown substance-a fan in the dry storage area had visible dusty and grime-a silverware caddy had a brown sticky substance on it-white metal shelves above the food prep area had chipped paint and rust on them During an interview on 4/15/2026 at 9:42 A.M., the DD indicated the bags of chicken and french fries in the freezer should have been sealed, the baking tray should have been clean, the fan in the dry storage should have been clean, the silverware caddy should have been clean, and the metal shelves should have been painted. During another observation of the kitchen and the Alcove (where food was served from the steam table) on 4/17/2026 at 11:45 A.M. the following was noted:-the ceiling over the prep area in the kitchen was dirty and the paint was peeling.--the Alcove ceiling vent and the ceiling and wall surrounding the vent was dusty and dirty; and 2 screens in the ceiling were black with a heavy accumulation of dirt and dust. On 4/17/2026 at 11:45 A.M., the DD indicated the peeling and dirty ceilings, vents, and screens, should have been clean. She also indicated maintenance had been notified of all of these issues but had not taken care of them yet. On 4/20/2026 at 10:25 A.M. a list of maintenance requests for the past 6 months was provided and the only issue listed was the peeling paint on the kitchen ceiling tiles. During observations of nutrition pantries on the units on 4/21/2026, the following issues were noted:-at 9:21 A.M. the [NAME] 2 unit refrigerator temperature was 46 degrees and the shelf in the freezer was rusty.-at 9:26 A.M. the Bridgeview unit refrigerator and freezer did not have thermometers and an employee's food was found in the refrigerator.-at 9:29 A.M. the East 2 refrigerator's thermometer was broken.-at 9:35 A.M. the East 1 coffee machine tray had a brown and white crust on it.-at 9:40 A.M. the [NAME] 1 cabinet drawer, under the coffee machine, was missing the outer layer of finish and the cabinet door was buckled. During an interview on 4/21/2026 at 9:40 A.M., the DD indicated the coffee machine tray should have been clean, the cabinet drawer and door should have been repaired, all refrigerators should have had working thermometers and the temperature of the refrigerator should be no higher than 41 degrees, and employee food should not have been stored in the nutrition pantry refrigerator. On 4/22/2026 at 3:00 P.M. the DON indicated a policy for cleaning and maintaining the kitchen environment was not available and indicated the facility followed state regulations.410 Indiana Administrative Code (IAC) 16.2-3.1-20(i)(3)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interview, the facility failed to ensure bugs were controlled in 1 of 1 kitchen. During an observation of the kitchen on 4/17/2026 at 9:53 A.M., multiple dead bugs were noted in a light fixture above the 3-compartment sink used to wash food preparation utensils. During an interview on 4/17/2026 at 9:53 A.M. the DD indicated bugs were a problem and had been reported to the maintenance department but it had not yet been addressed. On 4/20/2026 at 10:25 A.M. a list of maintenance requests for the past 6 months was provided and the only issue listed was the peeling paint on kitchen ceiling tiles. On 4/22/2026 at 2:00 P.M. a policy regarding pest control was requested but one was not provided before survey exit. 410 IAC 16.2-3.1-19(f)(4)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to obtain informed consent for psychotropic medication administration for 1 of 5 residents reviewed for unnecessary medications. (Resident 3)Findings include:The clinical record of Resident 3 was reviewed on 4/17/2026 at 8:45 A.M. The resident's diagnoses included, but were not limited to: gastrostomy status, difficulty in walking, dysphagia, chronic kidney disease, hypertension, personal history of malignant neoplasm of prostate, obstructive sleep apnea, irritable bowel syndrome, tremor, paroxysmal atrial fibrillation and polyneuropathy.A Quarterly Minimum Data Set (MDS) assessment, dated 2/24/2026, indicated the resident was moderately cognitively impaired and was taking an anticoagulant and an antidepressant.Physician Orders included, but were not limited to:Escitalopram Oxalate (antidepressant) Oral Tablet 10 mg (milligrams), give two tablets one time a day, 10/14initiated /2025 and Bupropion Hydrochloride (antidepressant) Oral Tablet 100 mg, give one tablet three times a day, initiated 10/22/2025.A Care Plan, initiated on 9/12/2025, indicated Resident 3 received an antidepressant medication. A Psychotropic Medication Consent form, dated and signed on 12/22/2025, for Resident 3 for the following medications: Escitalopram Oxalate 20 mg every morning and Bupropion Hydrochloride 100 mg three times a day.The clinical record for Resident 3 failed to evidence a signed psychotropic consent form dated prior to the resident beginning psychotropic medications.During an interview, on 4/17/2026 at 10:29 A.M., the Interim Director of Nursing (Interim DON) indicated he was unable to locate a signed psychotropic consent for either medication, the Escitalopram Oxalate or the Bupropion prior to the initiation of the medications for Resident 3. On 4/17/2026 at 11:21 A.M., the Executive Director provided a policy titled, Antipsychotic Medication Use, dated 1/5/2025 and indicated the policy was the one currently used by the facility. The policy indicated .The Physician/practitioner will respond appropriately.clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks.410 Indiana Administrative Code (IAC) 16.2-3.1-3(n)(2)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to update a resident's care plan for 1 of 3 residents reviewed for falls. (Resident 16) Finding includes: During an interview on 4/15/2026 at 10:42 A.M. Resident 16 indicated he had fallen several times. During an observation on 4/15/2026 at 10:42 A.M. a fall mat was noted on the floor next to Resident 16's bed. A record review was completed on 4/17/2026 at 1:24 P.M. for Resident 16. Diagnoses included, but were not limited to, Parkinson's and dementia. An admission Minimum Data Set (MDS) assessment, dated 4/6/2026, indicated Resident 16 was moderate.y cognitively impaired, required substantial assistance for toileting and bathing; and partial to moderate assistance for transfers. The assessment indicated the resident had had no falls since admission to the facility. In addition, the resident was receiving physical and occupational therapy during the time of the assessment. An admission Fall Risk Assessment, completed on 3/30/2026, indicated Resident 16 was a fall risk and had incurred a fall on 4/4/2026. The care plan regarding falls and interventions to prevent falls was not initiated until 4/13/2026, after the resident's fall. During an interview on 4/22/2026 at 1:27 P.M. the DON indicated the care plan should have been updated for the fall. On 4/22/2026 at 3:00 P.M. a current policy, dated 1/5/2025 and titled Care Planning-Current Comprehensive, was provided by the DON. The policy indicated, .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: When there is a significant change in the resident's condition 410 Indiana Administrative Code (IAC) 16.2-3.1-35(b)(1)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to assess a resident after a fall for 1 of 3 residents reviewed for falls. (Resident 16)1. During an interview on 4/15/2026 at 10:42 A.M. Resident 16 indicated he had fallen several times and had gone to the emergency room twice as a result of the falls.During an observation on 4/15/2026 at 10:42 A.M. a fall mat was noted on the floor next to Resident 16's bed.A record review was completed on 4/27/2026 at 1:54 P.M. for Resident 16. Diagnoses included, but were not limited to, dementia and Parkinson's.An admission Minimum Data Set (MDS) assessment, dated 4/6/2026, indicated Resident 16 had a moderate cognitive deficit; required maximum assist for bathing and toileting and required moderate assist for bed mobility and transfers. The assessment indicated the resident had had no falls since admission to the facility and received physical and occupational therapies.An admission Fall Risk assessment dated [DATE] indicated Resident 16 was at risk for falls.On 4/4/2026 an assessment for a change in condition and transfer to the emergency room indicated Resident 16 was being transferred for complaints of chest pain and follow up from a fall. No other documentation could be found regarding how the fall occurred or an assessment of the resident after the fall.A Care Plan problem initiated on 4/13/2026 indicated Resident 16 was at risk for falls. Interventions included, but were not limited to, bed in lowest position, footwear to prevent slipping, and keep call light and personal items in reach.During an interview on 4/22/2026 at 12:22 P.M. the DON indicated there was not an assessment related to the fall present in the record and an assessment should have been documented.On 4/22/20206 at 3:00 P.M. the DON provided a policy, dated 1/5/2025 and titled, Charting and Documentation. The policy indicated, .The following information should be documented in the resident medical record: Events, incidents, or accidents involving the resident 410 IAC 16.2-3.1-37(a)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure preventative measures were implemented for a resident with a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers.(Resident 10)Finding includes: A record review was completed on 4/17/2026 at 8:56 A.M. for Resident 10. Diagnoses included chronic obstructive pulmonary disease and a protein calorie deficit. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2026, indicated Resident 10 had a moderate cognitive deficit, a range of motion deficit on both sides of their lower extremities; required maximal assistance with bed mobility and transfers; was frequently incontinent of bladder, and was always incontinent of bowels and had no pressure ulcers. A care plan regarding the resident's risk for pressure ulcer development was initiated on 9/4/2025 with interventions encourage adequate hydration and nutrition, keep skin clean and dry, pressure reducing mattress, skin assessments as indicated, assess per risk of skin breakdown. There were no specific preventative interventions for the resident's heels addressed in the care plan. Physician Orders for Resident 10 included, but were not limited to:-4/13/2026 Regular diet with fortified foods 3 times a day.-8/15/2025 House supplement 1 time a day.-4/2/2025 Resident to wear heel protectors daily. May remove for wound and ADL care, then re-apply.-4/2/2026 Clean right lateral heel with normal saline and pat dry. Apply betadine to wound and leave open to air. A Care Plan problem, for Resident 10, initiated on 4/2/2026 indicated a skin impairment of a deep tissue injury to her right heel. Interventions included, but were not limited to, heel protectors while in bed and keep heels up while in bed. During an observation of wound care on 4/21/2026 at 11:04 A.M., Resident 10 was found in bed with no heel protectors and her heels were resting directly on the mattress. During an interview on 4/22/2026 at 10:53 A.M. the Wound Nurse indicated the resident had heel protectors ordered but staff were not applying them consistently and sometimes the resident would kick them off. She indicated the resident should have had her heels up off the mattress and heel protectors in place. On 4/22/2026 at 3:00 P.M. the DON provided a current policy, dated 1/5/2025 and titled, Pressure Injury Prevention and Management. The policy indicated, .Preventive interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences. Such interventions may include: Use of pressure reducing/relieving support surfaces or devices that assist with pressure redistribution and tissue load 410 Indiana Administrative Code (IAC) 16.2-3.1-40(a)(1)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to provide gastrostomy tube (G-tube) care as ordered by the Physician for 1 of 1 resident who was observed for G-tube care. (Resident 17)Finding includes: During an observation on 4/16/2026 at 10:12 A.M., LPN 5 removed Resident 17's dressing from around his G-tube and cleaned the skin with sterile water only and no soap. LPN 5 then applied a clean dressing around the G-tube insertion site. The skin around the G-tube insertion site was noted to be reddened. During an interview with LPN 5 on 4/16/2026 at 10:17 A.M., LPN 5 indicated she had not used soap and she was not sure if soap was supposed to be used during Resident 17's G-tube dressing change. Resident 17's record review was completed on 4/18/2026 at 11:00 A.M. Diagnoses included, but were not limit to: dysphagia, aphasia, hemiplegia, and hemiparesis of the left side. A Quarterly Minimum Data Set (MDS) assessment dated , 3/12/2026, indicated the resident was nonverbal, was rarely or never understood by others and rarely or never understood others, had significant cognitive impairment, was dependent on staff for all transfers, personal hygiene, showering/bathing and received 51% or more of his daily caloric requirements from a G-tube feeding. A current Physician's order, dated 4/12/2026, indicated Resident 17's G-tube site was to be cleaned with soap and water and a new drain sponge applied daily and as needed. A current Care Plan, initiated on 7/3/2025, indicated Resident 17 was at risk for complications related to the need for an enteral tube feeding (G-tube). An intervention initiated on 7/3/2025 indicated tube insertion site care should be performed per the Physician's order. On 4/16/2026 at 10:30 A.M., a policy regarding following Physician's orders and a policy regarding following the Plan of Care was requested, but neither were received before the survey exit on 4/22/2026 at 3:00 P.M. 410 Indiana Administrative Code (IAC) 16.2-3.1-44(b)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to ensure laboratory services were obtained timely for 1 of 5 residents whose labs had been reviewed. (Resident 84)Findings include: The clinical record of Resident 84 was reviewed on 4/17/2026 at 11:35 A.M. The resident's diagnoses included, but were not limited to: diabetes mellitus, peripheral vascular disease, hypertension, acidosis, acquired absence of right leg below knee, acquired absence of left leg below knee, and immunodeficiency due to conditions classified elsewhere.A Quarterly Minimum Data Set (MDS) assessment, dated 1/16/2026, indicated the resident was cognitively intact but did not indicate the resident had a peripherally inserted central catheter (PICC) line (a thin, flexible tube inserted into an upper arm vein and threaded to a large vein near the heart for long-term intravenous access).During an interview, on 4/16/2026 at 10:45 A.M., Resident 84 indicated he has had a PICC line and had completed intravenous (IV) antibiotics for a previous urinary tract infection, weeks ago. The resident indicated a urine sample had been sent to the lab, and the results were to have determined the removal of his PICC line. Resident 84 indicated he desired to have the PICC line removed and no one has followed up with his urine sample results yet.Physician Orders included, but were not limited to:Repeat urine with culture (a diagnostic test that detects and identifies bacteria or yeast in the urine to diagnose urinary tract infections), dated 4/3/2026Repeat urine with culture, dated 4/7/2026,Please obtain stat urine and culture to send to labs, dated 4/17/2026. A Nurse's Note, dated 4/4/2026 at 00:51A.M., indicated Resident 84 had completed his course of antibiotics.A Nurse's Note, dated 4/11/2026 at 10:42 A.M., indicated a urine sample had already been obtained from the resident but had not been received by the laboratory company.A Nurse's Note, dated 4/17/2026 at 3:18 P.M., indicated another urine sample from the resident had been collected from Resident 84.A Nurse's Note, dated 4/21/2026 at 1:32 P.M., indicated the urine sample was collected on 4/17/2026 and needed to be re-collected again as instructed by the laboratory.A Nurse's Note, dated 4/21/2026 at 6:17 P.M., indicated yet another urine sample was collected from Resident 84.During an interview, on 4/20/2026 at 3:00 P.M., LPN indicated there were no results for the resident's urinalysis (UA) (a diagnostic test that examines the appearance, concentration, and content of urine to detect disorders like urinary tract infections, kidney disease, and diabetes) and indicated it sometimes takes a while.During an interview, on 4/20/2026 at 3:16 P.M., the Director of Nursing (DON) indicated the facility had called the laboratory for Resident 84's urinalysis results on 4/16/2026 and indicated the laboratory had never received the resident's urine. The Interim DON indicated the facility had sent another urine sample on 4/17/2026.During an interview, on 4/21/2026 at 11:58 A.M., the DON indicated the laboratory had indicated there were no results for the UA for Resident 84 due to the urine sample not being labeled correctly with the date. On 4/22/2026 at 11:00 A.M., the DON provided a policy titled, Laboratory Services, dated 1/5/2025 and indicated the policy was the one currently used by the facility. The policy indicated .If the facility staff obtains a specimen for laboratory testing, the specimen will be:.laboratory testing to be completed and the date the specimen was obtained.9.Shoul d the laboratory test not be obtained, the physician/practitioner will be contacted for further guidance.410 IAC 16.2-3.1-49 (a)

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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin Health & Rehabilitation	20531 Darden Rd South Bend, IN 46637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure infection control practices were followed regarding emptying a urinal for 1 of 1 residents observed for urinal care. (Resident 40)Finding include:During an observation, on 4/21/2026 at 2:30 P.M., Certified Nurses Aid (CNA) 15 was exiting Resident 40's room carrying a half full urinal down the hallway. She continued down the hallway to the unit bathroom to empty the urinal. She had wet wipes in her hand grasping the urinal handle. She emptied the urinal but was not noted to wash her hands after emptying the urinal.During an interview with CNA 15, on 4/21/2026 at 2:32 pm, she indicated the way she carried the urinal was proper technique. She indicated that gloves were not to be worn in the hallway. CNA 15 indicated she had not washed her hands after emptying the urinal. She indicated she had had training on personal protective equipment but could not recall when that training had occurred.During an interview on 4/22/2026 at 12:11 PM with RN 14, she indicated staff were not supposed to go outside of resident rooms with gloves on their hands. RN 14 indicated staff were allowed to go outside of resident rooms with gloves on when they were emptying resident urinals due to the fact there were no bathrooms in many of the resident rooms. She confirmed staff must wear gloves when emptying a urinal.A policy titled Personal Protective Equipment-Donning and Doffing dated 1/5/2025, was provided by the Director on Nursing on 4/22/2026 at 10:08 A.M. the policy indicated. Specific Procedure/Guidance: 1. The staff, residents and visitors will be provided education on proper use and donning and doffing PPE. Donning 1. Identify the appropriate PPE to don based on the type of isolation/quarantine per physician's order. 2. Validate appropriate signage on resident's door. 3. Perform hand hygiene. 8. Put on gloves a. Ensure a size for appropriate fit.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(1)