STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155745	A. BUILDING -- B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS VILLAGE AT NOTRE DAME INC	54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556

(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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/16/2025 Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990 At this Emergency Preparedness survey, Holy Cross at Notre Dame, Inc., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 52 certified beds. 30 beds are dually certified for Medicare and Medicaid and 22 beds are certified for Medicare only. At the time of the survey, the census was 47. Quality Review completed on 04/22/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/16/2025 Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990	K 0000	*This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Armendarz Jennifer	DON	04/29/2025

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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	At this Life Safety Code survey, Holy Cross Village at Notre Dame Inc. was 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The 2019 Therapy Room and dining facility addition to the Murphy Wing were surveyed under Chapter 18, New Health Care Occupancies. This one-story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the Quinn Wing, which is a noncertified comprehensive care unit, in 2007. A Therapy Room and dining facilities were added to the existing Murphy Wing in 2019. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard-wired smoke detectors in resident sleeping rooms. The building is partially protected by a 200-kW diesel-powered emergency generator. The facility has 52 certified beds. 30 beds are dually certified for Medicare and Medicaid and 22 beds are certified for Medicare only. The facility had a census of 47 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered. Quality Review completed on 04/22/25		*taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.* **Holy Cross Village requests consideration for the desk review for all citations.**	
K 0232 SS=E	NFPA 101 Aisle, Corridor, or Ramp Width			

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Bldg. 01	Based on observation and interview, the facility failed to ensure furniture located in a corridor in 1 of 5 smoke compartments was securely attached to the floor or wall. LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect residents, staff and visitors in 1 of 5 smoke compartments. Findings include:	K 0232	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, visitors, or staff were affected.** **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken? There is a potential for all residents, visitors, and staff to be affected.** **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff chairs removed from hall. Staff educated on life safety concerns as well as where to located themselves to ensure hallway and call-lights can be monitored.** **4 How will the corrective actions be monitored to ensure the deficient practice will not recur? Monthly audits will be completed for 6 months to ensure hallways are clear of furniture that is not bolted to the floor or wall.** **5 By what date will the systemic changes for each deficiency be completed? May 4, 2025**	05/04/2025

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	Based on observation with the Maintenance Supervisor and Maintenance Technician 2 at 12:44 p.m. on 04/16/2025, two arm-chairs, that were not secured to the wall or floor, were located in the Murphy Wing corridor outside of resident sleeping room 102. Based on interview with the Maintenance Supervisor at 12:44 p.m. on 04/16/2025, when asked about the chairs, he stated "I have no idea. That is nursing." The corridor measured 8 feet in width with an unobstructed egress of more than six feet. This finding was reviewed with the Administrator, Maintenance Supervisor and Maintenance Technician 2 at the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect residents, staff and visitors in 2 of 5 smoke compartments. Findings include: Based on observation with the Maintenance Supervisor and Maintenance Technician 2 at 2:15 p.m. on 04/16/2025, an unsealed 1 inch by 4-inch penetration was observed around a pipe in the smoke barrier wall above the smoke compartment	K 0372	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, visitors, or staff were affected.** **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken? There is a potential for all residents, visitors, and staff to be affected.** **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The area noted to be out of**	05/04/2025

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	separation doors located in the Schwartz Wing near resident sleeping room 120. Based on interview at 2:15 p.m. on 04/16/2025 the Maintenance Technician 2 acknowledged the open penetration. This finding was reviewed with the Administrator, Maintenance Supervisor and Maintenance Technician 2 at the exit conference. 3.1-19(b)		**compliance was resealed on 4/24/25.** **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** **Preventative Maintenance work orders created to assess all 5 smoke barriers monthly and reviewed during monthly QAPI meetings.** **5 By what date will the systemic changes for each deficiency be completed?** May 4, 2025	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects residents, staff and visitors in 2 of 5 smoke compartments. Findings include: Based on observation with the Maintenance Supervisor and Maintenance Technician 2 at 1:05 p.m. on 04/16/2025, the set of smoke barrier doors next to the Brothers of Holy Cross office on the	K 0374	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected.** 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken? Potential for all residents, visitors, and staff to be affected.** 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ADC**	05/04/2025

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	Dujarie Hall had a ¼-inch gap along the center where the doors came together in the closed position. This was verified by the Maintenance Technician 2 at the time of observation using a tape measure to measure the gap. Based on interview at 1:05 p.m. on 04/16/2025, The Maintenance Supervisor and Maintenance Technician 2 acknowledged the gap measured ¼-inch. This finding was reviewed with the Administrator, Maintenance Supervisor and Maintenance Technician 2 at the exit conference. 3.1-19(b)		**installed 2 astragals on fire doors to seal the center.** 4 **How will the corrective actions be monitored to ensure the deficient practice will not recur? Smoke barrier doors will be inspected monthly x 6 and reviewed during monthly QAPI meetings.** **5 By what date will the systemic changes for each deficiency be completed?** May 4th, 2025	