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 _____	C 09/27/2024

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

(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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00442671. Complaint IN00442671 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: September 26 & 27, 2024 Facility number: 002668 Provider number: 155745 AIM number: 200325990 Census Bed Type: SNF/NF: 28 SNF: 19 Residential: 45 Total: 92 Census Payor Type: Medicare: 5 Medicaid: 7 Other: 35 Total: 47 Holy Cross Village at Notre Dame was found to be in compliance with 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00442671. Quality Review completed on 10/7/2024	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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
	155745	A. BUILDING _____ B. WING _____	C 09/27/2024

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

(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
F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff transferred a dependent resident with a mechanical lift in accordance with physician orders and the plan of care for 1 of 3 residents reviewed for mechanical lifts. (Resident E) This deficient practice resulted in a fall and the resident sustained a left shin fracture. The deficient practice was corrected on 7/31/2024, prior to the start of the survey, and was therefore past non-compliance. Finding includes: On 9/26/24 at 2:08 P.M., a review of the clinical record For Resident E was conducted. The resident's diagnoses included, but were not limited to: Multiple Sclerosis, dementia and seizures. A current Physician's order, initiated on 4/26/22, indicated the resident was to be transferred with a mechanical lift with the assistance of two (2) persons. A Care Plan, initiated on 7/19/22, and revised on 9/9/24, indicated the resident required assistance with Activities of Daily Living (ADLs) including transfers and toilet use related to impaired balance and mobility with decreased trunk control with muscle weakness due to diagnoses of Multiple Sclerosis and a seizure disorder. The	F 689	Past noncompliance: no plan of correction required.	

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 _____	C 09/27/2024

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

(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
F 689	Continued From page 2	F 689		

interventions included, but were not limited to: the resident required the use of a mechanical life with total assistance of 2 staff members for all transfers.

A current care plan related to the resident's fall risk, revised on 9/9/24 had no specific instructions related to utilizing the mechanical lift to transfer the resident.

A Fall Risk Assessment, dated 6/8/24, indicated the resident was a moderate risk for a falls.

An Annual Minimum Data Set (MDS) assessment, dated 6/10/24, indicated the resident was cognitively intact and independent for decision making, had no recent falls and was dependent on staff for chair to bed transfers.

A form titled, "CNA Assignments", undated and provided by the Director of Nursing indicated the resident's transfer status was a "Hoyer" mechanical lift.

A self-reported incident report, #344, dated 7/27/24 at 6:45 A.M., indicated Resident E was lowered to the floor during a transfer. No injuries were noted immediately after the fall. On 7/28/24 the resident complained of left ankle pain and a nurse provided an ibuprofen (an antiinflamatory medication utilized to treat mild pain) at 7:24 A.M. and notified the Nurse Practitioner (NP). A new order was received for a stat (immediately) x-ray. The results of the x-ray indicated there was a fracture of the left distal tibial metaphysis and fibular shaft (bones in the shin). The resident was transferred to a local ED (Emergency Department) for an evaluation. The incident report did not indicate failure of staff to utilize a

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 _____	C 09/27/2024

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

(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
F 689	Continued From page 3	F 689		

mechanical lift and failed to identify staff members involved in the incident.

A Nurse Progress Note, dated 7/27/24 07:00 A.M., indicated "...This writer called to resident room per CNA[Certified Nursing Assistant]. CNA stated she was getting resident up for the day and during transfer from bed to w/c [wheelchair] resident was lowered to the floor. CNA stated that resident foot got caught on bed railing and while placing resident on floor resident left ankle/foot got twisted. Resident assessment completed. No apparent injury noted at this time. Will continue to observe...." The note did not indicate the manner in which the CNA had attempted to transfer the resident.

A handwritten statement, by LPN 2, dated 7/28/24 and untimed, indicated, on 7/27/24 at 7:00 A.M., she was called into Resident E's room by a CNA. " ...When I walked into the room it was noted that resident was on the floor with her feet tangled on the railing on her bed ...." The resident was assessed by LPN 2 and resident appeared to have no injuries, so the resident was assisted off the floor and placed in bed. Resident E did complain of general discomfort and was administered an ibuprofen. The note explained Resident E continued to complain of discomfort, however, on 7/28/24, the resident had been more specific as to where her pain was located. LPN 2 assessed the left foot and found there were no issues with area being reddened, swollen or bruised. The resident was administered ibuprofen and the Nurse Practitioner (NP) was notified. A new ordered was received to obtain an x-ray of the left ankle.

A Nurse Progress Note, dated 7/28/24 at 7:35

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 _____	C 09/27/2024

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

(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
F 689	Continued From page 4	F 689		

A.M., indicated Resident E continued to complain of left foot/ankle pain from a previous incident. The note indicated ibuprofen was administered and the NP was contacted and a new order was received to obtain an x-ray of the left ankle.

A Nurse Progress Note, dated 7/28/20 at 1:58 P.M., indicated "... X-ray results received, shows fracture to left ankle. new order from on call NP to send to ER [emergency room] for eval and treat...."

An Emergency Department Progress Note, dated 7/28/24 at 4:29 P.M., indicated Resident E "...suffered a fall when staff was attempting to transfer her yesterday. Family states patient is nonambulatory/bedridden at baseline and requires complete assistance with transfers. Apparently her feet got tangles (sic) and she dropped to the ground. She was reporting some left ankle pain and noticed edema at that site so x-ray was obtained...."

A untimed, handwritten statement, by CNA 2, dated 7/28/24, indicated " ...I was trying to get her up but I can't find a sling to get her up so she told me to do what everyone [everyone] do her when they don't have no sling. She hug [sic] me to get her up her feet got stuck on the rails so I lower her down ...."

An untimed Corrective Action Form, dated 7/29/24, indicated LPN 2 did not notify facility management regarding Resident E's fall on 7/27/24. LPN 2 was provided with a final corrective action due to not notifying management of a fall, which resulted in a fracture.

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 _____	C 09/27/2024

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

(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
F 689	Continued From page 5	F 689		

An untimed Corrective Action Form, dated 7/31/24, indicated CNA 3 did not transfer Resident E with a mechanical lift, on 7/27/24, in accordance with the plan of care. CNA 3 was provided with a final corrective action, regarding the transfer of Resident E who had been transferred inappropriately without considering the plan of care, which resulted in a fall and injury to the resident.

During an interview, on 9/27/24 at 10:22 A.M., CNA 4 indicated she had never had any concerns about where to find a mechanical lift sling when she needed to transfer a resident via a mechanical lift. She indicated if a sling was not located in the resident's room it was probably being washed so slings could be in two places the laundry room and/or the clean utility room. She indicated the clean utility and laundry were accessible to her by a touch key pad.

During an interview, on 9/27/24 at 10:43 A.M., CNA 3 indicated she tried to transfer Resident E alone, on 7/27/24, and had to lower her to the floor. She indicated the resident was a mechanical lift, however she could not find a mechanical lift sling when she needed to transfer the resident. She indicated she had looked for one but the resident told her to "just do it like everybody else does it to me" so she tried to transfer the resident without the mechanical lift, by hugging onto the resident. CNA 3 indicated during the transfer the resident's leg got caught on the rail, of the bed, so she lowered her to the floor.

On 9/26/24 at 2:32 P.M., the DON provide a policy titled, "Resident Handling and Transfers", dated 9/2022, and indicated the policy was the

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 _____	C 09/27/2024

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

(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
F 689	Continued From page 6	F 689		

one currently used by the facility. The policy indicated " ...It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employee safe in accordance with current standards and guidelines ...13. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment ...."

On 9/26/24 at 2:32 P.M., the DON provide a policy titled, "Incidents & Accidents Policy", dated 2/2024 and indicated the policy was the one currently used by the facility. The policy indicated" ...Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident ...9. The supervisor or other designee will be notified of the incident/accident ...10. The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury (ies) ...."

The deficient practice was corrected by 7/31/24 after the facility implemented a systemic plan that included the following actions: the facility interviewed all parties involved, provided a corrective actions, education to ensure nursing staff would notify management of all incidents, whether there had been an injury or not, CNA's were educated to follow the plan of care, with results of education discussed in QAPI (Quality Assurance and Performance Improvement)

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 _____	C 09/27/2024

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

(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
F 689	Continued From page 7 meeting in August 2024 and no other concerns regarding mechanical lifts had been observed or reported; however observations continued to ensure resident safety. 3.1-45(a)(2)	F 689		