STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155745	A. BUILDING 00 B. WING	03/25/2024

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 19, 20, 21, 22, and 25, 2024 Facility number: 002668 Provider number: 155745 AIM number: 200325990 Census Bed Type: SNF: 19 NF: 29 Residential: 43 Total: 91 Census Payor Type: Medicare: 8 Medicaid: 9 Other: 31 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/1/24.	F 0000	**Holy Cross Village requests consideration for the desk review for all citations.** *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 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.*	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jen Armendariz	DON	06/03/2024

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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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to revise a care plan for an anti-anxiety medication for 1 of 15 residents whose care plans were reviewed. (Resident 8) Finding includes: A record review was completed on 3/21/2024 at 9:11 A.M. Resident 8's diagnoses included, but were not limited to hypertension, anxiety, depression, psychotic disorder, hemiplegia, and seizures. A Quarterly MDS (Minimum Data Set) Assessment, dated 2/16/2024, indicated the resident received antipsychotics, antidepressants, and hypnotic medication. A current Care Plan, dated 9/10/2022, indicated	F 0657	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The careplan for resident #8 was updated on 3/21/2024. 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents receiving psychotropic medications are potentially at risk for being affected. **3 What measures will be**	04/13/2024

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	Resident 8 utilized Ambien (a hypnotic) related to inability to sleep. A current Care Plan, dated 11/14/2023, indicated the resident had expressed feeling sad about not being able to use her left hand and losing her abilities. Interventions included, but were not limited to, staff will educate her regarding benefits, adverse effects, and risks of Ambien use. Monitor for adverse effects of Ambien use including but not limited to: rapid heart rate, nausea, vomiting, diarrhea, appetite loss, vision changes, low respiratory rate, new onset muscle cramps, nightmares, dizziness, and confusion. Follow with prescriber upon identification. Resident 8's current medication orders indicated the Ambien had been discontinued on 10/3/2023. During an interview on 3/21/2024 at 2:22 P.M., the Director of Nursing indicated the Care Plan should have been updated. On 3/21/2024 at 1:30 P.M., the Director of Nursing provided the policy titled,"Comprehensive Care Planning", dated 12/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment...." 3.1-35(d)(2)(B)		**put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing Leadership or designee will update resident careplans as psychotropic medication changes occur. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** DON or designee will audit careplans of those who have received medication changes weekly x 4 then monthly x5. Audit results will be reviewed monthly during QAPI. **5 By what date will the systemic changes for each deficiency be completed?** April 13,2024	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of			

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	a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to prevent the development of pressure areas for 1 of 3 residents reviewed for pressure areas. (Resident 9) Finding includes: During an interview, on 3/19/2024 at 10:36 A.M., Resident 9 indicated he had 3 open areas on his buttocks and he had developed them at the facility. A record review was completed on 3/20/2024 at 11:18 A.M. His current diagnoses included, but were not limited to diabetes, chronic kidney disease stage 3, bladder neck obstruction, and benign prostatic hyperplasia. A Quarterly MDS (Minimum Data Set) assessment, dated 2/20/2024, indicated Resident 9 was cognitively intact. Resident 9 required extensive assist of 2 staff for bed mobility and was totally dependant for transfers and toileting. The resident was incontinent of bladder and bowel and had 2 stage 2 pressure areas. A current Care Plan, dated 6/19/2023, indicated the resident had an ADL (activities of daily living)	F 0686	1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ADON met with resident and routine staff to discuss the importance of resident receiving prompt incontinence care. Due to resident's involvement in morning activities a scheduled timeframe was established which may vary slightly based on activities that resident chooses to attend. 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents who are incontinent and total dependence for transfers have the potential 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?** Nurse aides will be educated on the importance of incontinence care	04/13/2024

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	deficit and needed assistance with bed mobility, transfers, and toileting. Interventions included, but were not limited to, toilet Use: the resident is incontinent of bowel and bladder. Please provide incontinence care as soon after event as possible, including cleansing, application of barrier cream, clean brief and clothing change if needed. A current Care Plan, dated 9/18/2023, indicated the resident was incontinent of bladder and bowel and required assistance with toileting. Interventions included, but were not limited to change after each incontinent episode and as needed. Incontinent of bladder and bowel. At those times, please provide incontinence care as soon after episode as possible including cleansing, application of barrier cream, clean brief and clothing change if needed. A current Care Plan, dated 12/3/2023, indicated the resident had MASD (moisture associated skin damage) and had a history of multiple pressure areas. Interventions included, but were not limited to follow facility policies and protocols for the prevention of skin breakdown. Provide incontinence care as soon after event as possible including cleansing, application of barrier cream, clean brief and clothing change if needed, Check and change per facility protocol. A Braden Scale for Predicting Pressure Ulcer Risk, dated 2/19/2024, indicated the degree to which skin was exposed to moisture was documented as very moist: skin is often but not always moist. Degree of physical activity was documented as chairfast: Ability to walk severely limited or non existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. The score of the risk form totaled 15, indicating the resident was at mild risk for pressure ulcers.		and pressure injury prevention and maintenance. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** ADON or designee will complete a root cause analysis on all new or worsening facility acquired pressure injuries for 6 months. Results will be reviewed monthly in QAPI **5 By what date will the systemic changes for each deficiency be completed?** August 13, 2024	

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	A current Care Plan, dated 2/24/2024, indicated Resident 9 had Stage II pressure areas to the right buttock and gluteal fold and remains at risk for continued pressure ulcer development related to decreased mobility, problem with friction/shearing, and incontinence. Had a history of multiple pressure areas. Interventions included, but were not limited to Braden assessment quarterly, with condition change and as needed. Brief un-taped/open when in bed. Provide incontinence care as soon after event as possible including cleansing, application of barrier cream and/or ordered treatment. A Wound/Skin Healing Record, dated 1/11/2024 through 3/21/2024, indicated Resident 9 had a pressure area to the right upper thigh/lower buttocks. A Wound/Skin Healing Record, dated 1/11/2024 through 3/8/2024, indicated Resident 9 had a pressure area to the right buttocks near the coccyx, which had healed on 3/8/2024. A Wound/Skin Healing Record, dated 3/21/2024, indicated Resident 9 had a DTI (deep tissue injury) measuring 0.5 x 0.5 to the right buttocks. During an observation, on 3/22/2024 at 9:10 A.M., Resident 9 was observed in his wheelchair in the dining room. During an observation, on 3/22/2024 at 9:13 A.M., Resident 9 was in his room in his wheelchair reading papers. During an interview, on 3/22/2024 at 9:28 A.M., Resident 9 indicated he usually did not get checked for incontinence until he went to bed			

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	after lunch around 1:00 P.M. Resident 9 inquired, "am I supposed to tell them every time I go?" During an observation, on 3/22/2024 at 1:05 P.M., Resident 9 was up in his wheel chair. On 3/22/2024 at 1:20 P.M., Resident 9 was observed being transferred to his bed via a Hoyer Lift by CNA's 6 and 7. CNA 6 removed the brief from the resident, which was saturated with urine and had a strong smell. An area was observed to the right gluteal fold that was scabbed over, and open areas observed to the left gluteal fold, and also one to the coccyx which measured 3 x 2 cm. During an interview, on 3/22/2024 at 1:22 P.M., CNA 6 indicated the resident had been changed when he was assisted out of bed this morning. CNA 6 indicated he had been sitting up on the soaked brief since getting up this morning and should have been checked more. A Nurses' Note, dated 3/22/2024 at 4:25 P.M., indicated a re-assessment of the wound to the right upper buttock observed that area had "opened up" and was a stage 2 which measured 1 x 1.5 x <0.1. During an interview, on 3/25/2024 at 9:44 A.M., the ADON (Assistant Director of Nursing) indicated the resident should have been checked more for incontinence. On 3/22/2024 at 2:17 P.M., the ADON provided the policy titled,"Pressure Injury Prevention", dated 11/2023, and indicated the policy was the one currently used by the facility. The policy indicated..." This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment			

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	and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries... 3. Assessment of Pressure Risk...b... Examples of risk factors include, but are not limited to:...vii. Exposure of skin to urinary and fecal incontinence... 4. Interventions for Prevention and to Promote Healing...b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g. moisture management)...c. Evidence- based interventions fro prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present... ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives			

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	one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to provide timely incontinent care, for 1 of 2 residents who were reviewed for urinary incontinence. (Resident 9) Finding includes: A record review for Resident 9 was completed on 3/20/2024 at 11:18 A.M. His current diagnoses, included, but were not limited to diabetes, chronic kidney disease stage 3, bladder neck obstruction, and benign prostatic hyperplasia. A Quarterly MDS (Minimum Data Set) Assessment, dated 2/20/2024, indicated Resident 9 was cognitively intact. He required extensive assist of 2 staff for bed mobility and was totally dependant for transfers and toileting. The resident was incontinent of bladder and bowel, and had 2 stage 2 pressure areas. A current Care Plan, dated 6/19/2023, indicated the resident had an ADL (activities of daily living) deficit and needed assistance with bed mobility,	F 0690	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ADON met with resident and routine staff to discuss the importance of resident receiving prompt incontinence care. Due to resident's involvement in morning activities a scheduled timeframe was established which may vary slightly based on activities that resident chooses to attend. **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents who are incontinent have to potential to be affected. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient**	05/18/2024

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	transfers and toileting. Interventions included, but were not limited to toilet Use: the resident is incontinent of bowel and bladder. Please provide incontinence care as soon after event as possible, including cleansing, application of barrier cream, clean brief and clothing change if needed. A current Care Plan, dated 9/18/2023, indicated the resident was incontinent of bladder and bowel and required assistance with toileting. Interventions included, but were not limited to change after each incontinent episode and as needed. Incontinent of bladder and bowel. At those times, please provide incontinence care as soon after episode as possible including cleansing, application of barrier cream, clean brief and clothing change if needed. A current Care Plan, dated 2/24/2024, Resident 9 had Stage II pressure areas to the right buttock and gluteal fold and remains at risk for continued pressure ulcer development related to decreased mobility, problem with friction/shearing, and incontinence. Provide incontinence care as soon after event as possible including cleansing, application of barrier cream and/or ordered treatment. During an observation, on 3/22/2024 at 9:10 A.M., Resident 9 was observed in his wheelchair in the dining room. During an observation, on 3/22/2024 at 9:13 A.M., Resident 9 was in his room in his wheelchair reading papers. During an interview, on 3/22/2024 at 9:28 A.M., Resident 9 indicated he usually did not get checked for incontinence until he went to bed after lunch around 1:00 P.M. Resident 9 inquired,		**practice does not recur?** Nursing assistants were reeducated on Perineal Care Policy. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** DON or designee will complete random validation checklists for nursing assistants providing perineal care weekly x4 then monthly x 5. Results will be reviewed during monthly QAPI meetings. **5 By what date will the systemic changes for each deficiency be completed?** May 18, 2024	

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	"am I supposed to tell them every time I go?" During an observation, on 3/22/2024 at 1:05 P.M., Resident 9 was up in his wheel chair. On 3/22/2024 at 1:20 P.M., Resident 9 was observed being transferred to his bed via a Hoyer Lift by CNA's 6 and 7. CNA 6 removed the brief from the resident, which was saturated with urine and had a strong smell. An area was observed to the right gluteal fold that was scabbed over, an open area was observed to the left gluteal fold, and also one to the coccyx which measured 3 x 2 cm. During an interview, on 3/22/2024 at 1:22 P.M., CNA 6 indicated the resident had been changed when he was assisted out of bed this morning. CNA 6 indicated he had been sitting up on the soaked brief since getting up this morning and should have been checked more. During an interview, on 3/25/2024 at 9:44 A.M., the ADON (Assistant Director of Nursing) indicated the resident should have been checked more for incontinence. On 3/25/2024 at 9:50 A.M., the ADON provided the policy titled,"Incontinence Policy", dated 11/2023, and indicated the policy was the one currently used by the facility. The policy indicated"... Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services...." 3.1-41(a)(2)			
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication storage areas were free of expired medications, expired glucose testing solution, failed to ensure medications had resident identifiers, and failed to store medications in a safe/sanitary manner in a medication refrigerator, for 1 of 2 medications carts and 1 of 2 medication rooms observed. (Dujarie Medication Cart and Dujarie Medication Storage Room) Findings include:	F 0761	1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Expired meds were immediately discarded, unlabeled medications were labeled per policy. Medication refrigerators were all checked and defrosted if needed. **2 How will other residents who have the potential to be**	04/13/2024

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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
	1. An observation of the medication cart on the Dujarie Unit was completed with LPN 2 on 3/21/2024 at 9:07 A.M. a. The following medications and glucose testing solution were expired: - A bottle containing antacid tablets had an opened on date of 11/24/2023 and an expiration date of 9/2019 - An opened bottle containing vitamin D3 tablets had an expiration date of 2/2024 - An opened box of EvenCare G 2 solution (glucose testing solution) had an expiration date of 4/9/2021 b. The following medications did not have resident identifiers: - An opened box of anti-diarrheal tablets - An opened box of personal lubricant - An opened bottle of Vitamin D3 During an interview, on 3/21/2024 at 9:08 A.M., LPN 2 indicated the antacid tablets, Vitamin D3, and glucose control solution were expired and should not have been in the medication cart. The anti-diarrheal tablets, Vitamin D3, and personal lubricant were not labeled with a resident identifier, but should have a resident identifier. 2. During an observation of the medication storage room on the Dujarie Unit with LPN 2 on 3/21/2024 at 9:12 A.M., the medication refrigerator had a heavy build-up of ice on the back of the refrigerator. An interview with LPN 2 was completed, on 3/21/2024 at 9:15 A.M. LPN 2 indicated the medication refrigerator should not have an ice build-up.		**affected be identified and what corrective action will be taken?** All medication carts and medication refrigerators have the potential 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**? Policy for Medication Refrigeration Policy updated to include process for defrosting refrigerator if needed. Nurses and QMA's educated on procedures for medication storage and labeling requirements. Nurses and QMA's educated to look for ice build up in medication refrigerator and if noted how to defrost the refrigerator. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** Nursing leadership will audit medication/treatment carts and medication refrigerators weekly x4 then monthly x 5. Results will be reviewed monthly during QAPI. **5 By what date will the systemic changes for each deficiency be completed?** April 13th, 2024	

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	On 3/21/2024 at 10:00 A.M., the Director of Nursing provided a policy, dated 5/2023, and titled, "Medication Storage and Labeling Policy" The Director of Nursing indicated it was the current policy used by the facility. The policy indicated, "It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to to the manufacturer's recommendations and sufficient to proper sanitation, temperature, light, ventilation, moisture control, segregation and security... 9. All medications will be labeled in accordance with applicable federal and state requirements...." On 3/22/2024 at 9:40 A.M., the Director of Nursing provided a policy, dated 2/2024, and titled, "Medication Administration Policy" The Director of Nursing indicated it was the current policy used by the facility. The policy indicated, "...12. Identify expiration date. If expired, notify nurse manager...." 3.1-25 (l)(1)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food items in a cooler were sealed securely after opening, failed to have clean cooking utensils and skillets without missing Teflon, failed to ensure microwaves were clean and free of food debris, failed to remove expired foods, and failed to date foods when opened, in 1 of 1 kitchens and 1 of 3 pantries observed. This had the potential to affect the 47 of 48 residents who received meals from the kitchen. (Main Kitchen) Findings include: 1. During an initial tour of the kitchen, on 3/21/2024 at 10:00 A.M., with the Regional Director, the following was observed: - Cooking utensils with specs of dried foods. - Spatula with a burnt side. - Measuring cup with dried foods. - A microwave with a brown substance on the interior top, and another microwave with stuck on dried foods to the top of the inside. - A small cooler with cheese slices and a hunk of cheese not sealed appropriately/tight. - On a shelf were 5 skillets of various sizes with missing Teflon to the bottom and sides of the skillets. During an interview, on 3/21/2024 at 10:15 A.M.,	F 0812	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Dietary staff were educated on food storage and supply policy. Teflon pans were replaced non-Teflon pans. All cooking utensils and surfaces sanitized. Microwaves and refrigerators cleaned and sanitized.** 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents have the potential 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?** Food handling education will be provided upon hire, annually, and as needed to promote safe Food and	04/13/2024

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	the Regional Staff indicated the skillets would be thrown out, the utensils should have been cleaned, and the cheeses should have been sealed. 2. During an observation of the kitchen, on 3/19/2024, at 9:45 A.M. with the Regional Manager, there was an expired container of cottage cheese observed in the walk in cooler with a discard date of 3/14/2024. There were also 2 packages of expired lunch meat and 1 package of expired salad mix. During an interview, on 3/19/2024, at 09:51 A.M., with the Regional Manager, he indicated the expired foods should have been discarded. 3. An observation of the Dujarie panty was completed on 3/22/2024 at 10:32 A.M. with LPN 2. The following was observed: one opened and undated container of a yellow substance in the freezer. Two opened and undated bottles of thick and easy. The refrigerator shelves and door compartments had food substances and dried liquids. The microwave had a thick black film on its roof. During an interview, on 3/22/2024 at 10:35 A.M., LPN 2 indicated the shelves, compartments, and microwave should have been cleaned and the open items should have been dated. On 3/21/2024 at 1:05 P.M., the Regional Manager provided the policy titled, "Food and Supply Storage," dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated ... "Procedures: Cover, label and date unused portions and open packages. Products are good through close of business on the date noted on the label. Dry Storage: Store dry and staple items at least 6" above the floor and		Supply Storage and Cleaning of Food and Nonfood Contact Surfaces. All Teflon pans have been removed and new non-Teflon pans have been delivered and in use. Cleaning of Microwaves and Refrigerators are scheduled in Nurses Sation, Pantries, and Kitchen. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** The dietary manager or designee will perform daily inspections of kitchens and pantries to ensure food items are sealed correctly after opening as well as label and dating policies are being followed. The dietary manager or designee will perform weekly inspection to ensure the cleaning schedule of equipment is being followed. Results of inspection will be reported monthly during QAPI **5 By what date will the systemic changes for each deficiency be completed?** August 13, 2024	

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	18" below sprinklers ..." On 3/21/2024 at 1:05 P.M. the Regional Manager provided the policy titled, "Cleaning of Food and Nonfood Contact Surfaces," dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated ... "Food Contact Surfaces: Where equipment and utensils are used for the preparation of potentially hazardous on a continuous or production line basis, utensils and the food contact surfaces shall be washed, rinsed, and sanitized before and after each use with raw animal products; when changing from raw to ready eat products. The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Discard any food contact surfaces with chips, nicks, or broken pieces, such as fryer baskets or skimmers that have damaged, loose, or broken wires, strainers, pans, skillets, and knives, which cannot be cleaned properly. Ware-washing sinks must be equipped with detergent and sanitizer. Nonfood Contact Surfaces: The cavities and door seals of microwave ovens shall be cleaned at least once a day ...." 3.1-21(i)(l) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 19, 20, 21, 22, and 25, 2024 Facility number: 002668	R 0000	**Holy Cross Village requests consideration for the desk review for all citations.** *This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and*	

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	Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/1/24.		*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 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.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures			

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	of the personnel present. Based on interview and record review, the facility failed to ensure 12 fire and evacuation drills were completed throughout the year, specifically one drill completed per shift per quarter. This deficient practice had the potential to affect 48 of 48 residents who resided in the facility. Finding includes: On 3/21/24 at 10:07 A.M., the facility Life Safety Code binder was reviewed. The binder lacked documentation that a quarterly fire drill was conducted from April 2023 to June 2023 on 2nd shift, and that any drills were conducted in May of 2023 and February of 2024. On 3/21/24 at 11:45 A.M., during an interview with the Maintenance Director, he indicated fire drills were to be done monthly and on every shift at least every quarter and that a fire drill should have been completed on 2nd shift in the 2nd quarter. On 3/21/24 at 11:16 A.M., the policy titled, Emergency Preparedness, Fire Drills Policy," dated 3/2023, was provided by the Director of Nursing as current. The Policy indicated, "Fire drills will be conducted monthly on rotating shifts ...The Maintenance Director is responsible for scheduling and conducting fire drills and for maintaining documentation of the fire drills."	R 0092	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Fire drills were completed on 3/21/24 at 9:30pm for 2nd shift, 3/21/24 at 10:45pm for night shift, then again with Notre Dame Fire Department on 4/5/24 at 1:30 pm on 1st shift. **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken?** Entire facility has potential 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 Plant Operations Administrative Assistant or designee will schedule and verify documentation is complete for all fire drills and submit a copy of the documentation to the Administrator. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** Fire drill documentation will be submitted monthly x 12. Results will be reviewed monthly in QAPI.	05/28/2024

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			5 By what date will the systemic changes for each deficiency be completed? May 28, 2024	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview, and record review, the facility failed to complete semi-annual evaluations for 2 of 7 resident records reviewed. (Residents 7 & 5) Findings include: 1. During a record review for Resident 7, on 3/25/2024 at 9:00 A.M., semi-annual reviews were completed on 5/4/2023 and 1/19/2024. The record lacked the 2nd semi-annual review for 2023. During an interview, on 3/25/2024 at 9:15 A.M., the Assisted Living Manager indicated Resident 7 should have had another semi-annual review before the end of 2023.2. A record review was completed on 3/22/204 at 11:00 A.M. Resident 5 was admitted on 4/23/2023. Her diagnoses included, but were not limited to, history of falls, atrial fibrillation, and osteoarthritis. The clinical record lacked a semi-annual	R 0214	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #5 had an evaluation done on 9/12/23 which had been misfiled in spouse's chart. This was found prior to 3/25/24. Resident # 7 had been receiving outpatient therapy services from 10/2/23-12/20/23 with assessments for recertifications occurring 10/31/23 and 11/29/23. Resident discharged to the hospital on 12/22/23 then admitted to rehab on 1/4/23. Resident #7 had an evaluation on 1/19/24 to assess if appropriate to return to AL setting and when deemed inappropriate, family transferred resident to	04/13/2024

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	evaluation for October 2023. During an interview, on 3/22/2024 at 2:36 P.M., the Assisted Living Manager indicated she could not locate the semi-annual evaluation for October 2023. On 3/22/2023 at 2:45 P.M., the Assisted Living Manager provided the policy titled, "Service Plans", and indicated the policy was the one currently used by the facility. The policy indicated..."The Service Plan will be reviewed and revised at least semi-annually, and any time significant change occurs in the Resident's condition...."		another facility. **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents in Assisted Living have the potential 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?** Assisted Living Mgr will be training licensed nurses on how to complete evaluations to ensure timely completion. Assisted living manager will ensure that each resident semi-annual evaluation is completed. In the event the evaluation can not be completed due to resident availability this will be documented in the clinical chart and the evaluation will be completed as soon as possible once resident is available. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** DON or designee will audit evaluation compliance weekly x4 then monthly x5. Results will be reviewed monthly in QAPI. **5 By what date will the systemic changes for each**	

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			deficiency be completed? April 13, 2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food items in a cooler were sealed securely after opening, failed to have clean cooking utensils and skillets without missing Teflon, failed to ensure microwaves were clean and free of food debris, failed to remove expired foods, and failed to date foods when opened in 1 of 1 kitchens observed. This had the potential to affect 43 of 43 residents who received meals from the kitchen. (Main Kitchen) Findings include: 1. During an initial tour of the kitchen, on 3/21/2024 at 10:00 A.M., with the Regional Director, the following was observed: - Cooking utensils with specs of dried foods. - Spatula with a burnt side. - Measuring cup with dried foods. - A microwave with a brown substance on the interior top, and another microwave with stuck on dried foods to the top of the inside. - A small cooler with cheese slices and a hunk of cheese not sealed appropriately/tight. - On a shelf were 5 skillets of various sizes with missing Teflon to the bottom and sides of the skillets.	R 0273	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Dietary staff were educated on food storage and supply policy. Teflon pans were replaced non-Teflon pans. All cooking utensils and surfaces sanitized. Microwaves and refrigerators cleaned and sanitized.** 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents have the potential 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?** Food handling education will be provided upon hire, annually, and as	04/13/2024

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	During an interview, on 3/21/2024 at 10:15 A.M., the Regional Staff indicated the skillets would be thrown out, the utensils should have been cleaned, and the cheeses should have been sealed.2. During an observation of the kitchen, on 3/19/2024, at 9:45 A.M. with the Regional Manager, there was an expired container of cottage cheese observed in the walk in cooler with a discard date of 3/14/2024. There were also 2 packages of expired lunch meat and 1 package of expired salad mix. During an interview, on 3/19/2024, at 09:51 A.M., with the Regional Manager, he indicated the expired foods should have been discarded. On 3/21/2024 at 1:05 P.M., the Regional Manager provided the policy titled, "Food and Supply Storage," dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated ... "Procedures: Cover, label and date unused portions and open packages. Products are good through close of business on the date noted on the label. Dry Storage: Store dry and staple items at least 6" above the floor and 18" below sprinklers ..." On 3/21/2024 at 1:05 P.M. the Regional Manager provided the policy titled, "Cleaning of Food and Nonfood Contact Surfaces," dated 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated ... "Food Contact Surfaces: Where equipment and utensils are used for the preparation of potentially hazardous on a continuous or production line basis, utensils and the food contact surfaces shall be washed, rinsed, and sanitized before and after each use with raw animal products; when changing from raw to ready eat products. The food contact surfaces of all cooking equipment		needed to promote safe Food and Supply Storage and Cleaning of Food and Nonfood Contact Surfaces. All Teflon pans have been removed and new non-Teflon pans have been delivered and in use. Cleaning of Microwaves and Refrigerators are scheduled in Nurses Sation, Pantries, and Kitchen. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** The dietary manager or designee will perform daily inspections of kitchens and pantries to ensure food items are sealed correctly after opening as well as label and dating policies are being followed. The dietary manager or designee will perform weekly inspection to ensure the cleaning schedule of equipment is being followed. Results of inspection will be reported monthly during QAPI **5 By what date will the systemic changes for each deficiency be completed?** August 13, 2024	

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	shall be kept free of encrusted grease deposits and other accumulated soil. Discard any food contact surfaces with chips, nicks, or broken pieces, such as fryer baskets or skimmers that have damaged, loose, or broken wires, strainers, pans, skillets, and knives, which cannot be cleaned properly. Ware washing sinks must be equipped with detergent and sanitizer. Nonfood Contact Surfaces: The cavities and door seals of microwave ovens shall be cleaned at least once a day ...."			