STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY  COMPLETED		
ANDILAN	or correction	155745	B. WING	<del></del>	04/18/2024	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD STATE ROAD 933 NORTH		
HOLY CI	ROSS VILLAGE AT	NOTRE DAME INC	NOTR	E DAME, IN 46556		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
E 0000						
Bldg						
		paredness Survey was ndiana Department of Health in CFR 483.73.	E 0000			
	Survey Date: 04/1	8/2024				
	Facility Number: ( Provider Number: AIM Number: 200	155745				
	Cross at Notre Dan compliance with En Requirements for M	Preparedness survey, Holy ne, Inc., was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR				
	dually certified for	certified beds. 30 beds are Medicare and Medicaid. 22 nly for Medicare. At the time of sus was 49				
	Quality Review con	mpleted on 04/23/24				
K 0000						
Bldg. 01	Licensure Survey v	002668 155745	K 0000	This plan of correction also represents the facility's allegated of compliance. The following combined plan of correction at 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	nd d	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

Jen Armendariz DON 05/09/2024

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

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155745		(X2) MULTIPLE ( A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 04/18/2024			
	PROVIDER OR SUPPLIER	NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE		
	At this Life Safety (Village at Notre Da compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I. Health Care Occupa 2019 Therapy Room the Murphy Wing was 18, New Health Care This one story facility determined to be of was fully sprinklere in 1964 with the Du Murphy Wing in 19 is a noncertified con A Therapy Room at to the existing Murphas a fire alarm systelevels including in the corridors and har resident sleeping roprotected by a 200 ligenerator. The facility had a consurvey.  All areas where the access were sprinkly facility services are Quality Review corrections.	Code survey, Holy Cross me Inc. was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re, and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. The in and dining facility addition to were surveyed under Chapter re Occupancies  Type V (111) construction and ed. The original building built agarie Wing added in 1980, the 185 and the Quinn Wing, which in more than the care unit, in 2007. In addining facilities were added only Wing in 2019. The facility tem with smoke detection on all the corridors, in spaces open to and wired smoke detectors in oms. The building is partially kW diesel-powered emergency lity has 52 certified beds. 30 iffied for Medicare and are certified for Medicare only. The ensus of 49 at the time of this		taken in this plan of correct an admission that addition should have or could have taken by the facility to prevalleged deficiency. These are only included because of correction is required by	otion are pal steps been pent the steps a plan		
K 0351 SS=E	NFPA 101 Sprinkler System	- Installation					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3YTZ21

Facility ID: 002668

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
15574		155745	B. WING			04/18/2024	
			_	CTD FFT A	ADDRESS STEW STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
HOLY CROSS VILLAGE AT NOTRE DAME INC					STATE ROAD 933 NORTH		
HOLY CF	RUSS VILLAGE AT	NOTRE DAME INC		NOIRE	DAME, IN 46556		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Spinkler System -	Installation					
	2012 EXISTING						
	Nursing homes, a	nd hospitals where required					
	by construction typ						
		approved automatic					
		accordance with NFPA					
		ne Installation of Sprinkler					
	Systems.	To metalliation of opinition					
	-	nstruction, alternative					
	• •	es are permitted to be					
		inkler protection in specific					
		or local regulations prohibit					
	sprinklers.	or regulations promisit					
	In hospitals, sprinklers are not required in						
		patient sleeping rooms					
		the closet does not exceed					
		sprinkler coverage covers					
		t as required by NFPA 13,					
	Standard for Insta	· ·					
	Systems.	nation of opinition					
		19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	$ _{K0}$	351	1 What corrective action(	e)	05/09/2024
		ne ceiling construction in 1 of 5	I IX 0	331	will be accomplished for thos	-	03/07/2024
		ts in accordance with NFPA			residents found to have been		
	_	Installation of Sprinkler			affected by the deficient	•	
		, 2010 edition, Section 6.2.7.1			practice? The escutcheon pla	ate	
	_	heons, or other devices used			in room 134 was replaced on		
	-	space around a sprinkler shall			4/18/24 during this survey.		
		be listed for use around a			2 How will other residents	e	
		eient practice could affect			who have the potential to be		
	_				affected be identified and wh	at	
	approximately 10 residents and staff.  Findings include:				corrective action will be take		
					All resident rooms with a sprin		
	- manage merade.				are at risk for being affected.		
	Based on observation	ons during a tour of the facility			3 What measures will be	ļ	
		ce Director and Director of			put into place and what	ļ	
		04/18/24 between 11:27 a.m.			systemic changes will be ma	de	
	•	sprinkler head in the ceiling of			to ensure that the deficient	ue	
	_	and a missing escutcheon plate			practice does not recur? All	ļ	
	100HI 134 H	iau a missing esculcheon piate	1		practice does not recur? All	ļ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155745		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/18/2024				
	PROVIDER OR SUPPLIER	NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) LD BE COMPLETION ROPRIATE DATE		
	which left annular s which could possibl sprinkler head. Base observation, the Ma that the escutcheon have one replaced. T replaced during the	pace around the sprinkler head y delay the response of the ed on interview at the time of intenance Director confirmed plate was missing and would The escutcheon plate was survey.  Isseed with the Maintenance f Plant Operations and		resident rooms with sprin were checked do verify the scutcheon plates are in 4 How will the correct actions be monitored to the deficient practice with recur?  All resident rooms in SNF assessed quarterly to ensproper escutcheon plates place on each sprinkler. It inspections will be review completion during month meetings.  5 By what date will the systemic changes for each deficiency be completed 9, 2024	klers nat place. ctive ensure II not will be sure s are in Results of yed upon ly QAPI  he ach		
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with None Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR	<u> </u>					

CENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPL	LETED	
		155745	B. W	B. WING			/2024	
	NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC			STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556				
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE		ID		1		(X5)	
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE		
PREFIX TAG	automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation the facility failed to hydrants were conticulated operating condition periodically. NFP of the Inspection, 10 Water-Based Fire Programmer of the Inspection of the Inspected annually deficient practice of the Inspected of Inspected o	A 25, 2011 Edition, the Standard Festing, and Maintenance of Protection Systems, Table and dry barrel hydrants to be and after each operation. This build affect approximately all visitors.  On with the Maintenance of Plant Operations on 1:27 a.m. and 12:48 p.m., there can observed. One was in entrance next to the and hydrant was observed to be in entrance in the parking lot was located at the street end of the property. During een 09:02 a.m. and 11:25 a.m., hydrant inspection was dated cumentation was provided of a dated 07/11/22, however it did hydrant had been inspected ther two fire hydrants as being in interview at the time of observation, the Director of greed that the fire hydrant date. He went on to state that	K 0	PREFIX TAG	1 What corrective action will be accomplished for the residents found to have bee affected by the deficient practice? 5 fire hydrants, 3 f SNF and 2 for AL were insperand serviced on 4/22/2024. 2 How will other resident who have the potential to be affected be identified and will corrective action will be take No residents were directly affected. 3 What measures will be put into place and what systemic changes will be material to be put into place and what systemic changes will be material to ensure that the deficient practice does not recur? Se provider has been scheduled 4/1/2025 to ensure compliance maintained. 4 How will the corrective actions be monitored to ensure the deficient practice will not recur? Service provider will be sched for the following year after ear annual inspection is complete. Copies of the inspection report and next scheduled inspection be provided to the Administral annually. Results of inspection will be reviewed upon complete will be reviewed upon c	(s) ose n or or or or ore ded  ts hat en?  duled ch ed or	COMPLETION DATE  05/09/2024	
	_	does inspections of the			during monthly QAPI meeting			
	_	however he would have to get						
	into contact with the	e fire department to get the			5 By what date will the			
	proper documentation.				systemic changes for each			

deficiency be completed? May

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155745	B. WING 04/18/2024				
	ROSS VILLAGE AT	NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Findings were discu	issed with the Maintenance			9, 2024		
	Director, Director o	f Plant Operations and					
	Executive Director	at exit conference.					
	3.1-19(b)						
K 0511	NFPA 101						
SS=D	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and	Electric					
	Equipment using of	gas or related gas piping					
	complies with NFF	PA 54, National Fuel Gas					
		iring and equipment					
	complies with NFPA 70, National Electric						
	Code. Existing installations can continue in						
	service provided no hazard to life.						
	18.5.1.1, 19.5.1.1,		77.05				0.5.10.0.12.02.4
		on and interview, the facility	K 05	11	1 What corrective action(	•	05/09/2024
		f 1 ground fault circuit was properly maintained for			will be accomplished for thos		
		lectric shock. NFPA 70, NEC			residents found to have beer affected by the deficient	1	
	2011 Edition at 210				practice? The GFCI electric		
		Protection for Personnel,			receptacle in the restroom of r	oom	
	-	circuit-interruption for			134 was replaced on 4/18/24	00	
	-	provided as required in 210.8.			during this survey.		
	This deficient practi	ice could affect approximately			2 How will other resident	s	
	2 residents and staff	f.			who have the potential to be		
					affected be identified and wh	at	
	Findings include:				corrective action will be take	n?	
					All GFCI electric receptacles		
		on with the Maintenance			located in resident restrooms l	nave	
		or of Plant Operations on			the potential to be affected.		
		1:27 a.m. and 12:48 p.m., when			3 What measures will be		
		eceptacle in the restroom of			put into place and what	.d.	
		d with a GFCI tester, the GFCI trip and did not break the			systemic changes will be ma	ue	
	-	arip and did not break the			to ensure that the deficient practice does not recur? GFG	٦ <sub>ا</sub>	
		intenance Director agreed			receptacles in resident restroo		
		ot trip when tested with the			were assessed with GFCI Tes		
		I would get the outlet			to ensure proper function and	.01	
	-	t had been replaced by the end			compliance.		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155745		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/18/2024				
	PROVIDER OR SUPPLIER	NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERNCED TO THE AF DEFICIENCY)	ECTION (X5) DULD BE COMPLETION PPROPRIATE DATE			
	of the survey.  Findings were discu	issed with the Maintenance Director and Director of Plant		4 How will the corr actions be monitored to the deficient practice or recur? All GFCI resident restrope assessed Quarterly proper GFCI function. Finspections will be review completion during mont meetings.  5 By what date will systemic changes for deficiency be completed 9, 2024	ective to ensure will not  noms will to ensure Results of ewed upon thly QAPI  the each			
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care ro other UL standard used with general cords are not used wiring of a structure	ent - Power Cords and ent - Power Cords and ent - Power Cords and coatient care vicinity are only ints of movable and electrical equipment des that have been elified personnel and meet in 0.2.3.6. Power strips in coinity may not be used for personal electronics), in care resident rooms that is. Power strips for PCREE is UL 60601-1. Power strips the patient care rooms in meet UL 1363. In coms, power strips meet is. All power strips are precautions. Extension if as a substitute for fixed if and in the cords used moved immediately upon						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/18/2024 155745 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556 HOLY CROSS VILLAGE AT NOTRE DAME INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 What corrective action(s) 05/09/2024 failed to ensure 2 of 2 flexible cords were not used will be accomplished for those as a substitute for fixed wiring. NFPA-70/2011, residents found to have been 400.8 state unless specifically permitted in 400.7 affected by the deficient flexible cords and cables shall not be used for (1) practice? Extension cords in as a substitute for fixed wiring. This deficient rooms 134 and 113 were removed practice could affect approximately 4 residents on 4/18/24. and staff. How will other residents who have the potential to be Findings include: affected be identified and what corrective action will be taken? Based on observation during a tour of the facility All residents have to potential to with the Maintenance Director and Director of be affected. Plant Operations on 04/18/24 between 11:27 a.m. What measures will be and 12:48 p.m., resident room 134 had an extension put into place and what cord which was used to power a phone charger. systemic changes will be made Furthermore, an extension cord was located in to ensure that the deficient resident room 113 which powered a lamp. Based practice does not recur? on interview at the time of observation, the Document regarding power cords Director of Plant Operations acknowledged the being prohibited will be placed in extension cords and removed them upon admission packets for new observation. admissions. Approved hospital grade surge protectors have been The finding was reviewed with the Maintenance ordered and expected to arrive Director, Director of Plant Operations and 5/8/24. Nursing and Maintenance Executive Director during the exit conference. staff will be in-serviced extension cord use policy. 3.1-19(b) How will the corrective actions be monitored to ensure the deficient practice will not recur? All resident rooms in SNF will be assessed quarterly to ensure prohibited extension cords are not in use. Results of assessments will be reviewed upon completion

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155745		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  04/18/2024				
	NAME OF PROVIDER OR SUPPLIER  HOLY CROSS VILLAGE AT NOTRE DAME INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 54515 STATE ROAD 933 NORTH NOTRE DAME, IN 46556				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
K 0000				during monthly QAPI meeting  5 By what date will the systemic changes for each deficiency be completed? May 2024	gs.			
Bldg. 02	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 04/18  Facility Number: 0 Provider Number: 2000  At this Life Safety O Village at Notre Da compliance with Re Medicare/Medicaid Life Safety from Fit National Fire Protect Life Safety Code (L Health Care Occupa 2019 Therapy Room the Murphy Wing w 18, New Health Car  This one story facility determined to be of was fully sprinklere in 1964 with the Du Murphy Wing in 19 is a noncertified cor	02668 155745 325990 Code survey, Holy Cross me Inc. was found not in quirements for Participation in , 42 CFR Subpart 483.90(a), re, and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing uncies and 410 IAC 16.2. The in and dining facility addition to dere surveyed under Chapter	K 0000	This plan of correction also represents the facility's allegation of compliance. The following combined plan of correction allegations of compliance is submitted solely because it is required by law and is not an admission to any of the allegaticiencies or violations. Furthermore, none of the act taken in this plan of correction an admission that additional should have or could have betaken by the facility to prever alleged deficiency. These steare only included because a of correction is required by later the second states of the second states of the second seco	and  s ed ions n are steps een pt the eps plan			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155745	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/18/2024			
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP COD 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			IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	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. 22 beds are certified for Medicare only. The facility had a census of 49 at the time of this survey.  All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered							

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