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	04/18/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/18/2024 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. 22 beds are certified only for Medicare. At the time of the survey, the census was 49 Quality Review completed on 04/23/24	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: 04/18/2024 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
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 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. 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 Quality Review completed on 04/23/24		*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.*	
K 0351 SS=E	NFPA 101 Sprinkler System - Installation			

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Bldg. 01	Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Director of Plant Operations on 04/18/24 between 11:27 a.m. and 12:48 p.m., the sprinkler head in the ceiling of resident room 134 had a missing escutcheon plate	K 0351	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The escutcheon plate in room 134 was replaced on 4/18/24 during this survey. 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All resident rooms with a sprinkler are at risk for being 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?** All	05/09/2024

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	which left annular space around the sprinkler head which could possibly delay the response of the sprinkler head. Based on interview at the time of observation, the Maintenance Director confirmed that the escutcheon plate was missing and would have one replaced. The escutcheon plate was replaced during the survey. Findings were discussed with the Maintenance Director, Director of Plant Operations and Executive Director at exit conference. 3.1-19(b)		resident rooms with sprinklers were checked do verify that escutcheon plates are in place. **4 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 proper escutcheon plates are in place on each sprinkler. Results of inspections will be reviewed upon completion during monthly QAPI meetings. **5 By what date will the systemic changes for each deficiency be completed?** May 9, 2024	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, observation, and interview, the facility failed to ensure 3 of 3 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice could affect approximately all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director and Director of Plant Operations on 04/18/24 between 11:27 a.m. and 12:48 p.m., there were three fire hydrants observed. One was located near the main entrance next to the generator, the second hydrant was observed to be across from the main entrance in the parking lot and a third hydrant was located at the street corner in the North end of the property. During record review between 09:02 a.m. and 11:25 a.m., the most recent fire hydrant inspection was dated 06/01/22. Other documentation was provided of a fire hydrant report dated 07/11/22, however it did not indicate which hydrant had been inspected nor did it list the other two fire hydrants as being inspected. Based on interview at the time of record review and observation, the Director of Plant Operations agreed that the fire hydrant reports were out of date. He went on to state that the fire department does inspections of the facilities hydrants, however he would have to get into contact with the fire department to get the proper documentation.	K 0353	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 5 fire hydrants, 3 for SNF and 2 for AL were inspected and serviced on 4/22/2024. **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken?** No residents were directly 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?** Service provider has been scheduled for 4/1/2025 to ensure compliance is maintained. **4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** Service provider will be scheduled for the following year after each annual inspection is completed. Copies of the inspection report and next scheduled inspection will be provided to the Administrator annually. Results of inspections will be reviewed upon completion during monthly QAPI meetings. **5 By what date will the systemic changes for each deficiency be completed?** May	05/09/2024

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	Findings were discussed with the Maintenance Director, Director of Plant Operations and Executive Director at exit conference. 3.1-19(b)		9, 2024	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring 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, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect approximately 2 residents and staff. Findings include: Based on observation with the Maintenance Director and Director of Plant Operations on 04/18/24 between 11:27 a.m. and 12:48 p.m., when the GFCI electric receptacle in the restroom of room 134 was tested with a GFCI tester, the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed that the GFCI did not trip when tested with the surveyors tester and would get the outlet replaced. The outlet had been replaced by the end	K 0511	1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The GFCI electric receptacle in the restroom of room 134 was replaced on 4/18/24 during this survey. 2 **How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All GFCI electric receptacles located in resident restrooms 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?** GFCI receptacles in resident restrooms were assessed with GFCI Tester to ensure proper function and compliance.	05/09/2024

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	of the survey. Findings were discussed with the Maintenance Director, Executive Director and Director of Plant Operations 3.1-19(b)		**4 How will the corrective actions be monitored to ensure the deficient practice will not recur?** All GFCI resident restrooms will be assessed Quarterly to ensure proper GFCI function. Results of inspections will be reviewed upon completion during monthly QAPI meetings. **5 By what date will the systemic changes for each deficiency be completed?** May 9, 2024	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon			

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	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 failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 4 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Director of Plant Operations on 04/18/24 between 11:27 a.m. and 12:48 p.m., resident room 134 had an extension cord which was used to power a phone charger. Furthermore, an extension cord was located in resident room 113 which powered a lamp. Based on interview at the time of observation, the Director of Plant Operations acknowledged the extension cords and removed them upon observation. The finding was reviewed with the Maintenance Director, Director of Plant Operations and Executive Director during the exit conference. 3.1-19(b)	K 0920	**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Extension cords in rooms 134 and 113 were removed on 4/18/24. **2 How will other residents who have the potential to be affected be identified and what corrective action will be taken?** All residents 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 practice does not recur?** Document regarding power cords being prohibited will be placed in admission packets for new admissions. Approved hospital grade surge protectors have been ordered and expected to arrive 5/8/24. Nursing and Maintenance staff will be in-serviced extension cord use policy. **4 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	05/09/2024

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			during monthly QAPI meetings. **5 By what date will the systemic changes for each deficiency be completed?** May 9, 2024	
K 0000 Bldg. 02	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: 04/18/2024 Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990 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	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 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.*	

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	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 Quality Review completed on 04/23/24			