	OF HEALTH AND HUM					FO	TED: 06/17/2025 RM APPROVED
	R MEDICARE & MEDICA TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	IB NO. 0938-039 SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155506	A. BUILDING <u>00</u> B. WING			COMPLETED 04/28/2025	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS REHABILITATION AND WELLNESS			17475 [ADDRESS, CITY, STATE, ZIP COD DUGDALE DR I BEND, IN 46635			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION				(X5)
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TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	Licensure Survey. T Investigation of Con Complaint IN00454 related to the allega	55506 80860	F 00	000	Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed subsection because it is required by the provisions of federal and states.	ot ment the et ection olely	
	Medicare: 21						
	Medicaid: 38						
	Other: 7		1				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on interview and record review, the facility

failed to effectively act and resolve Resident Council's concerns related to long call light

response times. This failure affected 2 of 7

These deficiencies reflect State Findings cited in

accordance with 410 IAC 16.2-3.1.

483.10(f)(5)(i)-(iv)(6)(7)

Quality Review completed on 5/6/2025

Resident/Family Group and Response

Total: 66

F 0565

SS=D

Bldg. 00

TITLE (X6) DATE

06/06/2025

The facility requests paper

• what corrective action(s) will be

accomplished for those residents

compliance

Roger Garmendia Administrator 05/30/2025

F 0565

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155506		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/28/2025		
NAME O	F PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
HOLY (CROSS REHABILITA	ATION AND WELLNESS			DUGDALE DR I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	meeting.	the Resident/Surveyor group			found to have been affected b deficient practice:	y the	
	12:59 P.M., seven of Resident Council has times for their call seven residents reproduced delays, a waited as long as a soft weeks. A review of Reside revealed repeated call of the following months: - 1/27/2025	surveyor meeting on 4/22/25 at of seven residents indicated the ad complained about long wait lights to be answered. Two of orted they were experiencing and Resident B stated he had an hour within the past couple and Council meeting minutes oncerns over the past year light responses on the			A call light satisfaction survey completed with all long term interviewable residents includi Resident Council Members or 5/28/25. Concerns found are by addressed as individual grievances. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • A call light satisfaction survey was completed with all long terms.	ing n peing he	
	the Executive Direct been made aware of concerns regarding. He indicated he had causes for the issue response times: the second hold to propignored call light all already been answer provided. The ED indicated system had been act (Quality Assurance Improvement) mee Improvement Projetor both October 2	v on 4/24/2025 at 10:00 A.M., etor (ED) acknowledged he had f the Resident Council long call light response times. It identified two potential related to long call light call light system required a 2-3 perly reset and some staff larms assuming they had ered and care had been the call light concerns and light concerns and light concerns and laressed in the facility's QAPI and Performance tings and a Performance etc (PIP) had been implemented 024 and January 2025.			interviewable residents. Conce found are being addressed as individual grievances. All conce voiced in monthly resident countil be taken through the grieval process to assure all concerns addressed. Concerns will be tracked/trended and discussed QAPI for proper follow-up and process improvement. o All care staff will be re-eduction the proper use of the call list system and prompt response activated call lights. • what measures will be put in place and what systemic charm will be made to ensure that the deficient practice does not reconstructed.	cerns uncil vance s are d in ated ght to ages e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/28/2025 155506 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 17475 DUGDALE DR HOLY CROSS REHABILITATION AND WELLNESS SOUTH BEND, IN 46635 (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 had persisted. All care staff will be re-educated The ED indicated call light response times had by the compliance date on the been added to QAPI as a PIP in October 2024 and proper use of the call light system the plan had been closed out after two months and prompt because he was not receiving complaints from response to activated call lights. residents anymore. The ED indicated the staff had The Activities Director will be been educated on the call light system and the re-educated on taking all concerns need to hold the reset buttons on the call lights voiced in Resident Council through but he was unable to provide the documentation the grievance process. of the education prior to the exit of the survey. In January 2025, call lights were again added to QAPI as a Performance Improvement Plan (PIP) how the corrective action(s) will after several complaints. One intervention was the be monitored to ensure the facility had implemented was running daily reports deficient practice will not recur, for call light times and discussing the reports at i.e., what quality assurance the morning meetings. Another intervention was program will be put into place: to have an Administrator hold a call light pager while they were in the building and the on-call The IDT will complete random call manager held the call light pager while in the light satisfaction surveys twice a building on the weekends. The ED indicated after week for 4 weeks, weekly for 4 the Administrators left for the day, there was no weeks, and then monthly x4. one to monitor the call lights during the evening Concerns mentioned during the and night shifts. In addition, the ED indicated surveys will be addressed as staff had not followed up with the residents that individual grievances. The had experienced long call light wait times based Administrator or designee will on the call light response reports. He indicated the review the Resident Council maintenance department was aware of the problem minutes x6 months to assure and had worked on the system several times. concerns brought forward are Although the facility had implemented PIP plans, taken through the grievance the ED indicated he had based the call light wait process. Results of the surveys times on resident feedback, but again indicated no and review of Resident Council one had followed up with the residents who had Minutes will be taken to QAPI for experienced long call light wait/response times review/revision/tracking and from the call light report.. trending as appropriate. A review of the call light report was completed on 4/24/2025 at 11:00 A.M. The following dates and times had a call light response time of 30 minutes or longer. When asked what the facility considered a reasonable maximum call light wait/response time, the ED indicated he was not

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED
		155506	B. WING		04/28/2025
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD	
				DUGDALE DR	
HOLY CF	ROSS REHABILITA	ATION AND WELLNESS	SOUTH	I BEND, IN 46635	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	rame regarding when the call			
	_	een answered because the			
		been different based on what			
		ing on at the time the call light			
	went alarmed.				
		2 A.M. call light from room 24			
	took 45 minutes to				
		3 A.M. call light from room 1224			
		utes to be turned off.			
		6 A.M. call light from room 1214			
	took 51 minutes to				
	took 59 minutes to	A.M. call light from room 1220			
		A.M. call light from room 7 took			
	44 minutes to be tu	_			
		A.M. call light from room 1218			
	took 34 minutes to	_			
		A.M. call light from room 11			
	took 44 minutes to	_			
		A.M. call light from room 31			
		minutes to be turned off.			
	-4/10/2025 at 8:41	A.M. call light from room 22			
		minutes to be turned off.			
	-4/10/2025 at 12:23	3 A.M. call light from room 1220			
	took 59 minutes to	be turned off.			
	-4/10/2025 at 9:48	A.M. call light from room 14			
	took 35 minutes to	be turned off.			
	-4/10/2025 at 10:45	5 A.M. call light from room 5			
	took 56 minutes to	be turned off.			
	-4/10/2025 at 10:57	7 A.M. call light from room 19			
		minutes to be turned off.			
		7 A.M. call light from room 3			
	took 34 minutes to				
		P.M. call light from room 11 took			
	37 minutes to be tu				
		P.M. call light from room 16 took			
	34 minutes to be tu				
	-4/10/2025 at 2:10	P.M. call light from room 27 took			

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1 hour and 33 minutes to be turned off.

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155506		A. BUILDING 00 B. WING		COMPLETED 04/28/2025		
	F PROVIDER OR SUPPLIER CROSS REHABILITA	TION AND WELLNESS	1747	EET ADDRESS, CITY, STATE, ZIP COL 75 DUGDALE DR JTH BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	LD BE	(X5) COMPLETION DATE
TAG	-4/10/2025 at 2:28 lists minutes to be turn-4/10/2025 at 3:14 lists took 44 minutes to lists took 44 minutes to lists took 32 minutes to lists took 32 minutes to lists took 32 minutes to lists took 30 minutes to lists took 1 hour and 57 -4/10/2025 at 6:44 lists took 1 hour and 57 -4/10/2025 at 7:10 lists took 1 hour and 57 -4/10/2025 at 7:58 lists took 1 hour and 57 -4/10/2025 at 7:58 lists took 1 hours to be turn-4/10/2025 at 8:42 lists minutes to be turn-4/10/2025 at 10:01 hours and 26 minutes to be turn-4/10/2025 at 10:03 took 51 minutes to lists to list took 30 minutes to lists took 32 minutes took 36 minutes to lists to lists to lists to lists took 36 minutes to lists	P.M. call light from room 1122 be turned off. P.M. call light from room 28 took tes to be turned off. P.M. call light from room 1209 be turned off. P.M. call light from room 16 took med off. P.M. call light from room 1202 be turned off. P.M. call light from room 1122 minutes to be turned off. P.M. call light from room 15 took med off. P.M. call light from room 28 took med off. P.M. call light from room 11 took med off. P.M. call light from room 30 took med off. P.M. call light from room 30 took med off. P.M. call light from room 30 took med off. P.M. call light from room 11 be turned off. P.M. call light from room 11 be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11 and 1 minute to be turned off. P.M. call light from room 11	TAG	DEFICIENCY		DATE

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PRINTED: 06/17/2025

	FOF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155506	· /	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/28/2025		
	PROVIDER OR SUPPLIER	TION AND WELLNESS	STREET ADDRESS, CITY, STATE, ZIP COD 17475 DUGDALE DR SOUTH BEND, IN 46635					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
TAG	-4/11/2025 at 4:15 / took 1 hour and 9 m -4/11/2025 at 5:20 / 2 hours and 45 minuted of 11/2025 at 5:20 / 2 took 1 hour and 5 m -4/11/2025 at 6:35 / 2 took 2 hours and 7 m -4/11/2025 at 8:59 / 1 hour and 2 minuted of 11/2025 at 10:20 took 38 minutes to 11/2025 at 10:35 took 1 hour and 40 -4/11/2025 at 11:57 took 53 minutes to 11/2025 at 12:15 2 hours to be turned of 11/2025 at 1:10 1 hour and 8 minuted of 11/2025 at 1:39 1 2 hours and 48 minuted of 11/2025 at 3:20 1 1 hour and 28 minuted of 11/2025 at 3:30 1 1 hour and 10 minuted of 11/2025 at 3:36 1 1 hour to be turned of 11/2025 at 4:30 1 1 hour to be turned of 11/2025 at 6:41 1 1 59 minutes to be turned of 11/2025 at 6:46 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A.M. call light from room 16 A.M. call light from room 5 took utes to be turned off. A.M. call light from room 21 A.M. call light from room 21 A.M. call light from room 16 A.M. call light from room 16 A.M. call light from room 3 took es to be turned off. A.M. call light from room 3 took es to be turned off. A.M. call light from room 27 be turned off. A.M. call light from room 5 minutes to be turned off. A.M. call light from room 6 be turned off. A.M. call light from room 14 be turned off. P.M. call light from room 8 took es to be turned off. P.M. call light from room 20 took utes to be turned off. P.M. call light from room 11 took tes to be turned off. P.M. call light from room 3 took off. P.M. call light from room 3 took off. P.M. call light from room 3 took off. P.M. call light from room 16 took med off. P.M. call light from room 17 took med off. P.M. call light from room 18 D.M. call light from room 19 D.M. call light from room					DAIL	

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B took 54 minutes to be turned off.

48 minutes to be turned off.

40 minutes to be turned off.

-4/11/2025 at 8:21 P.M. call light from room 28 took

-4/11/2025 at 8:38 P.M. call light from room 27 took

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	X1) PROVIDER/SUPPLIER/CLIA	` ′				X3) DATE SURVEY COMPLETED	
or conduction	155506				04/28/		
			STREET ADDRESS, CITY, STATE, ZIP COD 17475 DUGDALE DR SOUTH BEND, IN 46635				
SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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			TAG	DEFICIENCY)		DATE	
41 minutes to be tur -4/11/2025 at 9:44 F 35 minutes to be tur -4/11/2025 at 10:39 took 1 hour and 29 r -4/11/2025 at 11:14 took 40 minutes to b This citation relates 3.1-19(u)	P.M. call light from room 5 took med off. P.M. call light from room 16 minutes to be turned off. P.M. call light from room 1217 be turned off.						
Encoding/Transmi Assessments Based on record rev failed to ensure the (MDS) assessment v in a timely manner of reviewed for dischar Findings include: Resident 29's record 04/23/2025 at 10:47 were not limited to: and arthritis. Resident 29 was dis Resident 29's Disch completed and subn after discharge. During an interview Director of Nursing assessment had not timely. The DON al	Discharge Minimum Data Set was completed and submitted for 1 of 4 residents who were rege assessments. (Resident 29) If review was completed on YAM. Diagnoses included, but hypertension, atrial fibrillation, charged on 12/22/2024. The arge MDS assessment was mitted on 4/23/2025, 122 days The on 04/28/25 at 11:15 AM, the (DON) indicated the MDS been completed or submitted so indicated the facility did not	F 06	40	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Discharge assessment for Resident 29 was completed, transmitted, and accepted on 4/23/25. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The MDS nurse/ designee will review the current open MDS assessments to ensure timely completion and transmittal		06/06/2025	
	SUMMARY S (EACH DEFICIEN REGULATORY OR -4/11/2025 at 9:15 If 41 minutes to be tur -4/11/2025 at 9:44 If 35 minutes to be tur -4/11/2025 at 10:39 took 1 hour and 29 If -4/11/2025 at 11:14 took 40 minutes to le This citation relates 3.1-19(u) 483.20(f)(1)-(4) Encoding/Transmit Assessments Based on record reversely failed to ensure the (MDS) assessment of the in a timely manner of the reviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischate in a timely manner of the interviewed for dischare in a timely manner of the interviewed for dischare in the interviewed for dischare in the interviewed for dischare. During an interviewed for dischare in the intervi	OF CORRECTION IDENTIFICATION NUMBER 155506 PROVIDER OR SUPPLIER ROSS REHABILITATION AND WELLNESS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION -4/11/2025 at 9:15 P.M. call light from room 13 took 41 minutes to be turned off. -4/11/2025 at 9:44 P.M. call light from room 5 took 35 minutes to be turned off. -4/11/2025 at 10:39 P.M. call light from room 16 took 1 hour and 29 minutes to be turned off. -4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. This citation relates to Complaint IN00454362. 3.1-19(u) 483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to ensure the Discharge Minimum Data Set (MDS) assessment was completed and submitted in a timely manner for 1 of 4 residents who were reviewed for discharge assessments. (Resident 29) Findings include: Resident 29's record review was completed on 04/23/2025 at 10:47 AM. Diagnoses included, but were not limited to: hypertension, atrial fibrillation, and arthritis. Resident 29 was discharged on 12/22/2024. Resident 29 was discharged MDS assessment was completed and submitted on 4/23/2025, 122 days	PROVIDER OR SUPPLIER ROSS REHABILITATION AND WELLNESS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION -4/11/2025 at 9:15 P.M. call light from room 13 took 41 minutes to be turned off4/11/2025 at 9:44 P.M. call light from room 16 took 1 hour and 29 minutes to be turned off4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. 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WING	PROVIDER OR SUPPLIER ROSS REHABILITATION AND WELLNESS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR IS CIDENTIFYING INFORMATION 4/11/2025 at 9:15 P.M. call light from room 13 took 41 minutes to be turned off. 4/11/2025 at 9:15 P.M. call light from room 16 took 15 minutes to be turned off. 4/11/2025 at 11:14 P.M. call light from room 16 took 40 minutes to be turned off. 4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. 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During an interview on 04/28/25 at 11:15 AM, the Director of Nursing (DON) indicated the MDS assessment to ensure timely completion and transmittal according to the RAI manual outstanding assessments will	FROVIDER OR SUPPLIER ROSS REHABILITATION AND WELLNESS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRICEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION 4/11/2025 at 9-15 P.M. call light from room 13 took 41 minutes to be turned off. 4/11/2025 at 9-15 P.M. call light from room 16 took 1 hour and 29 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. 4/11/2025 at 10-39 P.M. call light from room 1217 took 40 minutes to be turned off. This citation relates to Complaint IN00454362. 3.1-19(u) 483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility and to have been affected by the deficient practice. Discharge assessment for Residents 29 was completed, transmitted, and accepted on 4/23/205. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The MDS nurse/ designee will review the current open MDS assessment had not been completed or submitted timely. The DON also indicated the facility did not have a policy related to MDS assessment will be outstanding assessments will be	

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155506		JILDING	onstruction 00	COMPL	3) DATE SURVEY COMPLETED 04/28/2025	
	PROVIDER OR SUPPLIEF	TION AND WELLNESS	STREET ADDRESS, CITY, STATE, ZIP COD 17475 DUGDALE DR SOUTH BEND, IN 46635					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Assessment Instrunguidance.	nent (RAI) manual as their			required.			
	Page 2-17, a Discha completed (i.e., sign within 14 days after	AI User's Manual, Chapter 2, arge assessment must be ned and dated as complete) the resident had been a facility, and submitted within ion.			what measures will be put in place and what systemic chan will be made to ensure that the deficient practice does not recommend. The MDS nurse will be re-educated on timely complete and transmission of MDS assessments according to the manual.	ges e ur: ion		
					how the corrective action(s) to be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place: The MDS nurse/ designee will monitor the MDS tracker for open services.	,		
					assessments weekly for 4 we then monthly for 5 months to assure timely completion and transmission of assessments. Results of audits will be taken QAPI for review/revision as appropriate.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Impleme	nt Comprehensive Care Plan						
-	review, the facility comprehensive care	on, interview and record failed to develop a e plan for 2 of 17 residents lanning (Resident 22-bowel	F 00	656	The facility requests paper compliance • what corrective action(s) will accomplished for those reside		06/06/2025	

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Event ID:

45UD11 Facility ID: 001201

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155506	B. W.	ING		04/28/2025
NAME OF F	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	
					DUGDALE DR	
HOLY CF	ROSS REHABILITA	TION AND WELLNESS		SOUTH	H BEND, IN 46635	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	issues) and (Reside	R LSC IDENTIFYING INFORMATION		TAG		DATE
	issues) and (Reside	m 27-skin issues).			found to have been affected b deficient practice:	y the
	Findings include:				dencient practice.	
					1. Resident 22's care plan wa	s
	1. A record review	was completed on 4/23/2025 at			revised to reflect current order	
	9:01 A.M. for Resident 22. Diagnoses included,				issues and use of bowel	
	but were not limited	d to, Parkinson's disease and			medication.	
	chronic kidney dise	ase.			2. Resident 27's care plan wa	s
					revised to address the abdom	inal
		ge Minimum Data Set (MDS)			blister.	
		/29/2025, indicated Resident				
	-	moderately impaired and he			how other residents having t	l l
	was occasionally in	continent of bowels.			potential to be affected by the	
					same deficient practice will be	:
		cluded, but were not limited to:			identified and what corrective	
		145 micrograms (mcg) by			action(s) will be taken;	
	mouth daily for con	stipation. ylene glycol 17 grams by mouth			All some whome for LTC residen	4-
		8 ounces of water for			All care plans for LTC residen	ts
	constipation.	o dunces of water for			will be reviewed by the IDT to assure the care plans are	
	_	ate sodium 100 milligrams (mg)			comprehensive.	
	by mouth twice a da				comprehensive.	
		1				
		care plan that addressed			what measures will be put in	
		ding constipation, and the use			place and what systemic chan	
	of bowel medication	ns.			will be made to ensure that the	
		1/05/0005			deficient practice does not rec	eur
	_	on 4/25/2025 at 1:40 P.M., the				
		although Resident 22 received			The Interdisciplinary team will	
		ications for his bowels, there			re-educated on the process fo	
	-	ldressing the bowel issues or			developing, updating and review	ewing
	medication use.	vation of a medication			comprehensive care plans.	
		4/23/2025 at 8:51 A.M.,			how the corrective action(a) :::	ill bo
		lime-sized blister located			how the corrective action(s) w monitored to ensure the defici	
		G-tube site on his abdomen.			practice will not recur, i.e., who	
	•	e blister was new and attributed			quality assurance program wil	
		by the G-tube tubing being			put into place:	1 00
		inted to a band-aid located			put lillo piace.	
		f Resident 27's abdomen and			The DON or designee will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155506	B. W	ING		04/28/	2025
	PROVIDER OR SUPPLIER	TION AND WELLNESS	-	17475	ADDRESS, CITY, STATE, ZIP COD DUGDALE DR BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		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)		DATE
		nt had developed a similar			complete a random audit of ca		
	I -	earlier due to friction from the			plans that have been reviewed	-	
		he resident's skin. LPN 4			the Care Conference team we	-	
		nt did not have an order for			for 4 weeks, then monthly for		
		second blister and she did not			months to assure care plans a	ire	
		had created a Care Plan to ter formation from the G-tube.			comprehensive. Results of audits will be taken	to	
	address further offst	ter formation from the G-tube.			QAPI for review/revision as	10	
	Resident 27's record	d review was completed on			appropriate.		
		AM. Diagnoses included, but			appropriate.		
	were not limited to:	_					
	rhabdomyolysis, dy	sphagia, and chronic kidney					
	disease.						
		imum Data Set (MDS)					
		/28/2025, indicated the had a					
	G-tube.						
	There was no care r	plan for Resident 27 to address					
	_	ed by his gastostomy tube.					
		ea of me gastestom, tace.					
	A Nurse's Progress	Note, dated 04/21/2025,					
	indicated, "Blister n	noted to belly near G-Tube					
	holder, red, unopen	ed, possibly due to friction					
	_	be and clamp. Repositioned					
	_	n paper tape and blister					
		aid for protection. Clinical Care					
	Coordinator (CCC)	was aware."					
	During an interview	with the Director of Nursing					
	_	5 at 10:59 A.M., the DON					
	, ,	27 should have had a G-tube					
	care plan created af						
	1						
	On 4/25/2025 at 1:1	8 P.M., the Director of Nursing					
	(DON) indicated the	e facility did not have a policy					
	related to creating c	are plans and the facility used					
	the Nursing Standar	rds of Practice for creating care					
	plans.						

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06/17/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155506 B. WING 04/28/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 17475 DUGDALE DR HOLY CROSS REHABILITATION AND WELLNESS SOUTH BEND. IN 46635 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE American Nurses Association (ANA), Nursing: Scope and Standards of Practice, 4th Edition, 2021, included, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes. The plan reflects current evidence, is derived from the assessment, and is modified as needed in response to the patient's condition or situation...." 3.1-35 (d) F 0684 483.25 SS=D Quality of Care Bldg. 00 Based on observation, interview and record F 0684 The facility requests paper 06/06/2025 review, the facility failed to ensure the skin of a compliance resident with a Gastronomy tube (G-tube) did not · what corrective action(s) will be develop blisters caused by the friction from the accomplished for those residents G-tube for of 1 of 6 residents who were reviewed found to have been affected by the for skin problems. (Resident 27) deficient practice: Resident 27's care plan was Finding includes: revised to ensure interventions are in place for blister prevention. The During an observation of a medication family and physician were notified, administration on 04/23/2025 at 8:51 A.M., and a treatment order was Resident 27 had a dime-sized blister directly obtained. located below the G-tube site on his abdomen. LPN 4 indicated the blister was new and attributed · how other residents having the it to friction caused by the G-tube tubing being potential to be affected by the too long. LPN 4 pointed to a band-aid located same deficient practice will be toward the center of Resident 27's abdomen and identified and what corrective indicated the resident had developed a similar action(s) will be taken; blister several days earlier due to friction from the All residents with a G-Tube will be tubing rubbing on the resident's skin. LPN 4

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indicated the resident did not have an order for

know if the facility had created a Care Plan to

Resident 27's record review was completed on

the treatment of the second blister and she did not

address further blister formation from the G-tube.

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reviewed to ensure proper

positioning of catheter and

prevention measures are in place

to prevent friction. All current wounds were reviewed to assure

proper notifications, treatment

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155506	B. W	ING	_	04/28/	/2025
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					DUGDALE DR		
HOLY C	ROSS REHABILITA	TION AND WELLNESS		SOUTH	I BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	04/23/2025 at 10:5	1 AM. Diagnoses included, but			orders and care plans are in p	lace.	
		cerebral infarction,					
		sphagia, and chronic kidney			• what measures will be put in	to	
	disease.				place and what systemic chan		
					will be made to ensure that the	-	
	A Nurse's Progress Note, dated 04/21/2025,				deficient practice does not rec		
	indicated, "Blister noted to belly near G-Tube					,	
	holder, red, unopen, possibly due to friction and				All active clinical staff will be		
		and clamp. Repositioned			re-educated on proper position	ning	
	_	h paper tape and blister			of G-Tube to avoid friction inju	-	
	<u> </u>	aid for protection. Clinical Care			All active nurses will be		
	Coordinator (CCC)	-			re-educated on the processes	to	
	Coordinator (CCC) was aware.				follow if a wound is noted.		
	Resident 27's record	d lacked the documentation					
	that the provider ha	d been notified of the new					
	-	reatment of the new blister had			• how the corrective action(s)	will	
	been obtained, or a	Care Plan had been created			be monitored to ensure the		
	after either blister d	leveloped.			deficient practice will not recui	-,	
					i.e., what quality assurance		
	During an interview	w with the CCC and the Director			program will be put into place:		
	of Nursing (DON)	on 4/25/2025 at 10:59 A.M., the					
	CCC indicated she	had been notified verbally			The DON or designee will		
	about the blister bu	t because the notification was			complete a random audit to		
	verbal, she had forg	gotten to follow up. The CCC			ensure proper positioning of		
	indicated the provid	der and family had not been			G-tubes; The DON or designe	e will	
	notified but should	have been and the resident's			complete a random audit of ne	€W	
	plan of care should	have been updated. The CCC			wound documentation to assu	re	
	indicated, in addition	on, physician orders should			proper notifications, care plan		
		regarding treatment of the			interventions and treatment or	ders	
	blister and preventa	tive treatments for the G-tube			are in place weekly for 4 week	ïS,	
	site. The DON indi	cated Resident 27 should have			then monthly for 5 months.		
	had a care plan crea	ated for a G-tube after the first			Results of audits will be taken	to	
	blister had formed				QAPI for review/revision as		
					appropriate.		
	On 4/25/2025 at 1:1	18 P.M., the Director of Nursing					
	(DON) indicated th	e facility did not have a policy					
		rovider for a change in the					
	resident's condition	or a policy related to creating					
	care plans. The DO	N indicated the facility used					
	-	rds of Practice for contacting					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 04/28/2025			
	ROSS REHABILITA	TION AND WELLNESS	17475	ADDRESS, CITY, STATE, ZIP COD DUGDALE DR 1 BEND, IN 46635		
(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 APPROPRIA DEFICIENCY)	\TE	(X5) COMPLETION DATE
F 0757 Bldg. 00	Scope and Standard 2021, included, "The communicates effect This includes timely communication with regarding changes in registered nurse devencompassing strate outcomes. The planderived from the as needed in response situation." 3.1-37 (a) 483.45(d)(1)-(6) Drug Regimen is laborated to ensure their an antipsychotic means reviewed for unnected and the strategy of the strategy o	ssociation (ANA), Nursing: s of Practice, 4th Edition, e registered nurse stively in all areas of practice. y and appropriate h healthcare providers n patient conditionThe relops a collaborative plan egies to achieve expected reflects current evidence, is sessment, and is modified as to the patient's condition or Free from Unnecessary riew and interviews, the facility re was adequate monitoring of edication for 1 of 5 residents ressary medications. (Resident Resident 25 was completed on one. M. The resident's diagnoses no limited to: hypertension, enxiety, depression, bipolar	F 0757	The facility requests paper compliance • what corrective action(s) will accomplished for those reside found to have been affected by deficient practice: Resident 25 had an AIMS assessment completed on 4/1 • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All LTC residents with orders antipsychotic medications were	ents by the 16/25 the for	06/06/2025

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indicated the resident had no potential indicators

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reviewed to assure an AIMS

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLE			TED
		155506	B. WI	NG		04/28/20	025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			DUGDALE DR		
HOLY C	ROSS REHABILITA	TION AND WELLNESS			H BEND, IN 46635		
	T				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		havioral symptoms, had not			assessment has been comple	ted	
		ejection of care and had no			according to Standard of		
	_	rs. In addition, the MDS			Practice.		
	assessment indicated the resident was receiving an antipsychotic, an antidepressant, an				bat management will be must in		
		diuretic medication.			what measures will be put in		
	anticoaguiant and a	difference medication.			place and what systemic chan will be made to ensure that the		
	A Physician Order	dated 2/20/2025, indicated the			deficient practice does not rec		
	resident was to rece				delicient practice does not rec	ui.	
		ng (milligrams) tablet oral six			The clinical leadership team w	_{iill}	
	times weekly for bi				be re-educated on the standar		
	unios woomy for or	Po 4.1301.441.			practice for AIMS assessment		
	A Pharmacy Consultation Report, dated 8/8/2024,				produce for / mile desections	·	
		IMS (Abnormal Involuntary					
		or similar assessment be			• how the corrective action(s)	will	
	·	dent 25, as one had not been			be monitored to ensure the		
	completed in the pr	evious 6 months.			deficient practice will not recui	۲,	
					i.e., what quality assurance		
	A Pharmacy Consu	ltation Report, dated 9/17/2024,			program will be put into place:		
	indicated a second	request for an AIMS					
	assessment, or simi	lar assessment, be completed			The DON or designee will		
	for Resident 25. Th	ne recommendation was signed			complete random audits of LT	C	
		vider. However, an AIMS			residents with orders for		
		completed for Resident 25			antipsychotic medications to		
	until 1/19/2025.				assure an AIMS assessment		
					completed according to standa		
		n, revised 1/19/2025, indicated			of practice weekly for 4 weeks		
		liagnosis of bipolar disorder			then monthly x 5 months. Res		
		h an antipsychotic medication.			of audits will be taken to QAP		
		led, but were not limited to:			review/revision as appropriate		
	perform an AIMS t	est quarterly and as needed.					
	During on intermier	v, on 4/24/2025 at 3:22 P.M., the					
	_	of Nursing (ADON) indicated					
		en on an antipsychotic and had					
		nt completed in January and					
		ADON indicated the facility's					
	_	ing to complete AIMS					
		idents taking antipsychotic					
		quarter or with any new dosage					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 04/28/2025			
	ROVIDER OR SUPPLIER	TION AND WELLNESS	17475	ADDRESS, CITY, STATE, ZIP COD DUGDALE DR H BEND, IN 46635	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION changes. During an interview, on 4/25/2025 at 10:02 A.M., the Social Services Worker (SSW) indicated she created the care plans for the residents in conjunction with the Unit Manager. SSW indicated the interventions in the care plan were		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	Manager or other nuindicated she was used AIMS assessments. During an interview ADON indicated the policy regarding AI standard was to persevery 6 months on a antipsychotic. 3.1-25(i)	letion by herself and the Unit arsing management. SSW insure how the completion of were being monitored. To on 4/25/2025 at 2:52 P.M., the ere was no written facility MS but that the facility form an AIMS assessment any resident taking an			
F 0812 Bldg. 00	Based on observation failed to ensure the working order for 1 deficient practice has 66 residents who recommend from the finding includes: On 4/21/2025 at 9:2 included the norther area of the kitchen. underneath into the pipe in addition to the unable to be turned	be/Prepare/Serve-Sanitary on and interview, the facility kitchen equipment was in of 1 kitchen reviewed. This ad the potential to affect 66 of ceived meals from the kitchen. 66 A.M., an observation mmost sink of the cooking This sink was leaking drainage area from the drain the faucet slowly running and off.	F 0812	The facility requests paper compliance • What Corrective action(s) wi accomplished for those reside found to have been affected by deficient practice: The leaking faucet and drain to be repaired be the compliance date. • How other residents having potential to be affected by the same deficient practice will be identified and what corrective	ents by the will e the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155506		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/28/2025		
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD DUGDALE DR		
HOLY CROSS REHABILITATION AND WELLNESS					H BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
	the Dietary Manager indicated Maintenance was			1110	action(s) will be taken:		D.III
		sink and she indicated					
	maintenance was w	raiting for a part to fix the sink.			All sinks and drains in the kitch	hen	
	D	4/24/2025 + 1 44 D.M (1			were inspected for proper		
	_	or, on 4/24/2025 at 1:44 P.M., the tor indicated he had never			functionality. Repairs are being completed as needed.		
		ler for the kitchen sink and was			completed as needed.		
		ken sink in the kitchen.			What measures will be put in	ito	
	-				place or what systemic change		
	_	v, on 4/24/2025 at 1:51 P.M.,			will be made to ensure that the		
	_	n 1 indicated she was unaware			deficient practice does not rec	ur:	
		in the kitchen and stated, " I ugh there and haven't noticed			All active distant staff will be		
	anything."	ugh there and haven't hoticed			All active dietary staff will be re-educated on submitting a w	ork	
	uny ming.				order to Maintenance.	OIK	
	On 4/24/2025 at 3:	15 P.M., the Director of Nursing					
		policy titled, "Director of					
	_	ndated and indicated the			How the corrective action(s)	will	
		currently used by the facility.			be monitored to ensure the		
		d, "the Director of Dining and conducts safety, sanitation,			deficient practice will not recui i.e., what quality assurance	,	
	and maintenance pr				program will be put into place:		
		15 P.M., the DON provided a			The IDT will complete random		
		stered Dietitian", undated and			audits of sinks and drains in th		
		was the one currently used policy indicated, "The			kitchen weekly for 4 weeks, the monthly x 5 to ensure proper	en	
		nset and communicate			functionality. Results of audits	s will	
	_	nicate, and reinforce high			be taken to QAPI for	• ••••	
	standard in all areas	s, monitor performance and			review/revision as appropriate		
	addresses issues"						
	3.1-19(bb)						
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention						
<u>-</u>			F 0	880	The facility requests paper		06/06/2025
		on, record review and			compliance		
	interview, the facility failed to ensure enhanced				what corrective action(s) will	be	

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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 00 B. WING 04/28/2025 155506 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 17475 DUGDALE DR HOLY CROSS REHABILITATION AND WELLNESS SOUTH BEND, IN 46635 (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 barrier precautions were followed for 2 of 5 accomplished for those residents residents reviewed for isolation needs. (Resident found to have been affected by the 27 and 35) deficient practice: CNA 3 and LPN 4 have been Findings include: educated on enhanced barrier precautions protocol and 1. The clinical record of Resident 35 was reviewed Transmission Precaution signage. on 4/24/2025 at 10:26 A.M. The resident's diagnoses included, but were no limited to: diabetes mellitus, septicemia, obstructive how other residents having the uropathy, hypertension, anxiety and depression. potential to be affected by the same deficient practice will be An Annual Minimum Data Set (MDS) assessment, identified and what corrective dated 2/24/2025, indicated Resident 35 was action(s) will be taken; moderately cognitively impaired, was taking an antibiotic and had an indwelling catheter. All residents on enhanced barrier precautions have the potential to A Physician Order, dated 10/19/2024, indicated be affected. All direct care staff Resident 35 was to be in enhanced barrier will be re-educated on enhanced precautions; with instructions noted to maintain barrier precautions protocols and enhanced barrier precautions during high-contact Transmission Precaution signage. resident care activities. what measures will be put into A current Care Plan, created 5/31/2024, indicated place and what systemic changes Resident 35 required enhanced barrier precaution will be made to ensure that the isolation. deficient practice does not recur: During an observation and interview on 4/24/2025 All direct care staff will be at 11:08 A.M., CNA 3 entered Resident 35's room re-educated on enhanced barrier without any PPE (personal protective equipment precautions protocols and or gear worn to minimize exposure to workplace Transmission Precaution Signage. hazards that could cause serious injuries or illnesses, such as chemical, radiological, physical, how the corrective action(s) will electrical, or mechanical hazards) in place. The be monitored to ensure the PPE cart was located outside of the resident's deficient practice will not recur, room door. CNA 3 then performed hand hygiene i.e., what quality assurance with hand sanitizer and donned clean gloves once program will be put into place: inside Resident 35's room but she did not don a gown or a mask. CNA 3 then transferred Resident The Infection 35 from her bed to her wheelchair. CNA 3 exited Preventionist/designee will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED			
	155506			B. WING			04/28/2025	
		10000			_	0 1/20/	2020	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
	no (ibbit off bol ibi				DUGDALE DR			
HOLY C	ROSS REHABILITA	ATION AND WELLNESS		SOUTH	BEND, IN 46635			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION					DATE	
	Resident 35's roon	n after removing her gloves and			complete a random audit of			
	performed hand hy	ygiene. CNA 3 indicated she			residents on EBP to ensure st	aff		
	was unaware the re	esident was on "contact			follow proper enhanced barrie	r		
	precautions" as CN	NA 3 indicated the nurse had			precaution procedures 2x/wee	k for		
	not instructed her	regarding the need for			4 weeks, then weekly for 4 we			
		precautions. CNA indicated if			then monthly x4.	•		
	_	n enhanced barrier precautions,			Results of audits will be taken	to		
		een following the policy and			QAPI for review/revision as			
	worn a gown and i				appropriate.			
	8				арр. орнало.			
	2. During an obser	vation of a medication						
		04/23/2025 at 8:51 AM, LPN 4						
		O milliliter (mL) water flush to						
		ostomy tube while only wearing						
		s not wearing a gown when she						
	_	lush. An Enhanced Barrier						
		sign was hanging on Resident						
	27's to room door.							
	278 to 100111 door.							
	During an intervie	w on 04/23/2025 at 8:58 AM,						
		Lesident 27 was in EBP and she						
		a gown while administering the						
	flush.	a gown white administering the						
	Trasii.							
	Resident 27's reco	rd review was completed on						
		51 AM. Diagnoses included, but						
		o: cerebral infarction,						
		ysphagia, and chronic kidney						
	disease.	yspinagia, and ememe kidney						
	A current Physician's order, dated 02/04/2025,							
	indicated Resident 27 was on EBP.							
	A current Care Plan, initiated on 01/28/2025, indicated Resident 27 was on EBP related to a Gastrostomy Tube (G-tube).							
	Gasirosioniy Tube	(O-140C).						
	On 04/22/2025 +h	e Assistant Director of Nursing						
		a policy, dated 11/12/2024, and						
	utled "infection Pi	revention." The ADON						

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PRINTED: 06/17/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155506		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED 04/28/2025	
			A. BUILDING B. WING	00		
			STREET	ADDRESS, CITY, STATE, ZIP COD	·	
NAME OF I	PROVIDER OR SUPPLIEF	₹		DUGDALE DR		
HOLY CF	ROSS REHABILITA	ATION AND WELLNESS	SOUTH	H BEND, IN 46635		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		policy currently used by the indicated: "2. Enhanced				
		The use of gown and gloves				
		sident care activities may be				
	_	ntact Precautions do not				
		r nursing home residents with				
	chronic wounds and	d/or indwelling medical				
	devices regardless	of MDRO colonization"				
	3.1-18(a)					
F 0921	483.90(i)					
SS=D	` '	anitary/Comfortable Environ				
Bldg. 00	Care/i unotional/o	amary/comortable Environ				
Ü	Based on observation	on and interview the facility	F 0921	The facility requests paper	06/06/2025	
	failed to ensure wat	ter faucets were functional in 4		compliance		
	of 30 rooms in the l	long term care unit. (Rooms		what corrective action(s) will be	e e	
	W7, W12, W15 and	d W24)		accomplished for those residen		
				found to have been affected by	the	
	Findings include:			deficient practice:		
	1. During an observ	vation on 4/25/2025 at 2:00		The faucets in rooms W7, W12	,	
	P.M., the faucet in	Room W7 was running and		W15, and W24 have been		
	could not be turned	off.		repaired.		
	During an interview	v on 4/25/2025 at 2:00 P.M.,		how other residents having the	e	
	_	ed it had been running for		potential to be affected by the		
	quite awhile but did	not know how long. She had		same deficient practice will be		
		cility but it had not been fixed		identified and what corrective		
	*	he turned her television		action(s) will be taken;		
	_	o she forgot about it and was				
	able to sleep.			All sinks in long term care were		
	2 During an ab	votion of Poom W24 or		inspected for functionality. Sink		
	I -	vation of Room W24 on A.M., the faucet was missing		to be found malfunctioning have been scheduled for repair.	,	
		inuously dripping down the		been scheduled for repair.		
	back of the sink.	macasi, ampping down the		what measures will be put into	,	
				place and what systemic change		
	3. During an obser	vation of W15 on 4/22/2025 at		will be made to ensure that the		

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9:44 A.M., the faucet was dripping continuously.

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deficient practice does not recur:

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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 00 COMPLETED 155506 B. WING 04/28/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 17475 DUGDALE DR HOLY CROSS REHABILITATION AND WELLNESS SOUTH BEND, IN 46635 (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 4. During an observation of Room W12 on All active staff will be re-educated 4/22/2025 at 9:45 A.M., the faucet was dripping on the process of submitting work continuously. orders to Maintenance. In addition, the Maintenance Director will be During a tour and an interview on 4/25/2025 at re-educated on prompt response 2:35 P.M., the Maintenance Director indicated he to work orders. had tried to fix the faucets but they needed to be replaced and he was not sure how many leaking sinks the facility had but admitted there were how the corrective action(s) will several. He indicated he had ordered new parts be monitored to ensure the several months ago, and the parts had come in, deficient practice will not recur, but he was now waiting on a new tool that he had i.e., what quality assurance ordered. When asked when the tool was ordered program will be put into place: he returned with the tool indicating it had just been delivered, and he would begin fixing the The IDT will do a random audit of leaking faucets. sinks in resident rooms weekly for 4 weeks, then monthly x 5 to On 4/25/2025 at 2:35 P.M. dates of work orders for ensure proper functionality. leaking faucets and invoices, or purchase orders Results of audits will be taken to for parts and tools were requested, but none were QAPI for review/revision as provided prior to the exit of the survey. appropriate. During an interview on 4/28/2025 at 11:00 A.M., the ED. indicated the facility did not have a policy for maintenance of the building. 3.1-19(f) F 9999 Bldg. 00 F 9999 The facility requests paper 06/06/2025 3.1-14 PERSONNEL compliance (q) Each facility shall maintain current and • What Corrective action(s) will be accurate personnel records for all employees. The accomplished for those residents personnel records for all employees shall include found to have been affected by the the following: deficient practice

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
155506		155506	B. WI	ING		04/28/2025	
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u>. </u>	
NAME OF	PROVIDER OR SUPPLIE	ER			DUGDALE DR		
HOLVC	ROSS REHABILIT	ATION AND WELLNESS			H BEND, IN 46635		
HOLIO	TOOG REHABIEH	ATTOM AND WELLINESS		00011			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)	DATE	
	1 1	of orientation to the facility			No residents were affected by		
	and to the specific	job skills.			practice. Employees 10, 11 ar		
					12 had a job specific orientation		
	This state rule is n	ot met as evidenced by:			validation completed on 5/29/2		
	D 1 1				Employee 8 and Employee 9		
		eview and interview, the facility			had a TB screening put in place	ce	
		nployees received a job specific			on 5/29/25.		
		f 10 employees whose personnel			l	a	
	records were revie	wed. (Employees 10, 11 and 12)			How other residents having the standard leading to the standard leading t		
	Findings include:				potential to be affected by the		
	rindings include:				same deficient practice will be identified and what corrective	;	
	During a raviasy of	f employee personnel records on			action(s) will be taken:		
	_	5 A.M., Employee 10's record			action(s) will be taken.		
		b specific orientation.			Employee files will be audited	by	
	lacked a signed joi	specific offendation.			the Human Resources	Dy	
	During a review of	f employee personnel records on			Manager/Designee to ensure	ioh	
	_	A.M., Employee 11's record			specific orientation and TB	Job	
		b specific orientation.			screens are in place.		
					Serverile and in place.		
	During a review of	f employee personnel records on			What measures will be put in	nto	
	_	5 A.M., Employee 12's record			place or what systemic chang		
	lacked a signed jol	specific orientation.			will be made to ensure that the		
					deficient practice does not rec	eur:	
	During an intervie	w on 4/23/2025 at 9:00 A.M., the					
		ob specific orientations for			The Human Resources mana	ger	
	Employees 10, 11	and 12 were missing from the			will be re-educated on assuring	ıg job	
	employee personn	el records.			specific orientation and TB		
					screening are completed upor	n hire	
	, , ,	g personnel records was			and kept in the employee file.		
	requested on 4/23/2025 at 11:30 A.M. and again on 4/28/2025 at 1:15 P.M. but none was provided						
	prior to the time of	f exit of the survey.			How the corrective action(s)	will	
					be monitored to ensure the		
	3.1-14				deficient practice will not recu	۲,	
	(2)(1) 4 (1)				i.e., what quality assurance		
		of employment, or within one (1)			program will be put into place:	•	
		ployment, and at least annually					
		ees and nonpaid personnel of			The Human Resources	. [
facilities shall be screened for tuberculosis. For				manager/designee will comple	ete a		

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		X1) PROVIDER/SUPPLIER/CLIA	· ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u> B. WING			COMPLETED 04/28/2025	
		155506	B. W	-		04/28/2	UZ3
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
HOLY CROSS REHABILITATION AND WELLNESS					DUGDALE DR I BEND, IN 46635		
	T				I	Т	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	(X5)
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
		who have not had a			random audit of new employe	e T	
	documented negative	ve tuberculin skin test result			files to ensure job specific		
		g twelve (12) months, the			orientation and TB screenings		
		skin testing should employ the			in place weekly for 4 weeks, th	nen	
		the first step is negative, a performed one (1) to three			monthly x5.		
		first step. The frequency of			Results of audits will be taken QAPI for review/revision as	iO	
		lepend on the risk of infection			appropriate		
	with tuberculosis.	1			-1		
	This state rule was i	not met as evidenced by:					
	Based on record review and interview, the facility						
	failed to ensure, at t	the time of employment, 2 of					
		wed were screened for					
		ng the two-step Mantoux					
		ng method. (Employees 8 and					
	9)						
	Findings include:						
	During a review of	Employee 8's personnel					
	1	25 at 11:00 A.M., there was no					
		first and second step					
	1 '	est. Employee 8 had a hire date					
	of 10/14/2024.						
	During a review of	Employee 9's personnel					
	_	25 at 11:05 A.M., there was no					
		first and second step TB test.					
	Employee 9 had a h	ire date of 8/26/2024.					
	On 4/28/2025 at 12	:00 P.M. the ADON provided a					
		ransmission Reduction					
	Program" and dated	14/1/2014. The policy					
		igues receive baseline					
		ng upon hire and annual					
		based on the THSC					
	Community's risk classification or state specific requirements"						

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

PRINTED: 06/17/2025

FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155506	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/28/2025	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS REHABILITATION AND WELLNESS				STREET ADDRESS, CITY, STATE, ZIP COD 17475 DUGDALE DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	I				1		I

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