STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Cross Rehabilitation and Wellness	17475 Dugdale Dr South Bend, IN 46635

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47419 Based on record review and interviews the facility failed to ensure a resident received the required transfer assistance for 1 of 2 residents reviewed for accident hazards. (Resident E) Finding includes: The record for Resident E was reviewed on 6/24/24 at 1:41 P.M. Resident E's diagnoses, included but were not limited to: cerebrovascular accident and osteoporosis. The Admission Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident E's cognition was moderately impaired and she was dependent on staff to complete all activities of daily living (ADLs) including transfers. A care plan for Resident E, dated 5/23/24, indicated the resident had a self care deficit related to right side hemiparesis and staff were to transfer the resident with the extensive assistance of 2 staff members. During an interview on 6/24/24 at 1:53 P.M., Resident E's family member indicated during her visit on 6/6/24, the resident told her she had fallen and her leg was injured. During an interview on 6/24/24 at 1:42 P.M., the DON indicated during the investigation of the incident regarding a potential fall for Resident E and leg injury, all staff who had cared for Resident E on 6/6/2024 were interviewed and no one was aware and/or had witnessed any falls for Resident E. However, a CNA reported she had transferred the resident without any assistance from another staff person. An x-ray was completed on 6/8/24 for Resident E and indicated the resident had a non-displaced fracture of the right tibia and fibula. The Nursing Progress notes, dated 6/8/24, indicated the resident's family member was notified of the fracture, the resident was sent to the emergency room for an evaluation and was later admitted to the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 11:54 A.M., CNA 3 indicated when she received her assignments for her shift she checked the computer for any care information for her residents. There was a Resident Care Summary posted on the inside of the resident's closet doors. If a resident required a 2 person transfer, she would ask a co-worker for help. If another CNA was not available she would ask the nurse or a staff member from a nearby unit for help. CNA 3, when asked directly why she had transferred Resident E by herself previously, gave no reason for the incorrect transfer. CNA 3 kept repeated the above information regarding where she obtained resident information regarding the care needs of her assigned residents. During an interview on 6/25/24 at 11:32 A.M., the DON indicated the facility did not have a policy regarding following resident's plan of care. She initiated there had not been any other issues or resident injuries reported regarding CNA 3 not following the plans of care. This citation relates to complaint IN00436381. 3.1-45(a)(2)