

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/17/2025
NAME OF PROVIDER OR SUPPLIER  Holy Cross Rehabilitation and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>(continued on next page)</p>

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
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to adequately address resident grievances regarding call light wait times for 18 of 18 residents reviewed for call-light wait times, (Residents B, C, D, E, F, G, H, K, L, M, N, P, Q, R, S, T, and U). Findings include: During an interview, on 9/17/25 at 9:10 A.M., the Director of Nursing indicated the facility call light system was in working order and had not been out of working order at any time that she was aware of. The Director of Nursing indicated that each resident had a staff member, called a Guardian Angel, who checked on their assigned residents addressing concerns including concerns regarding call light wait times. The Director of Nursing indicated when residents had concerns, the Guardian Angel was to address the concern and/or file a grievance or complete a Call Light Response Survey form. The Director of Nursing provided a call light audit form that had been created following the previous annual survey on 4/28/25, and indicated call light wait time audits were ongoing but there was no audit documentation completed after 6/30/25. The Director of Nursing indicated there was no further documentation of call light monitoring after 6/30/25. There was no explanation as to why the auditing had been discontinued after 6/30/25. On 9/17/25 at 9:58 A.M., during a telephone interview with Resident B's family member, she indicated Resident B's call light often went unanswered, or staff turned the light off and did not return. During an interview, on 9/17/25 at 10:20 A.M., the Assistant Director of Nursing (ADON) indicated when residents initiated the call button from their rooms, the call went to a beeper system, first to the Aide on the floor, then if not answered in a certain amount of time, the floor nurse was alerted via the beeper system. The ADON indicated there were no lights outside resident doors and no lights at the nurse's station to visualize when call-lights had been activated by the residents. The ADON indicated that the aides and nurses were responsible for checking the beepers frequently. The ADON indicated that the facility no longer utilized their call light monitoring system because the facility felt the call light times were accurate due to nursing staff not consistently turning the call light off when resident's needs had been met. The Assistant Director of Nursing indicated the call light system was in place at the most recent Annual Survey on 4/28/25 when the facility had been cited for excessive call light wait times. The Assistant Director of Nursing could not say when the call light monitoring system had been discontinued. The Assistant Director of Nursing indicated the facility did not have a specific policy regarding the answering of call lights nor was there an expectation of a reasonable period of time when a call light should be answered. She indicated the facility followed Nursing Standards of Practice, but was unable to indicate what the Nursing Standard of Practice was for a reasonable period of time a resident should have to wait for their call light to be answered. The ADON indicated an Education/In-service had been completed on 8/5/25 in response to a grievance that had been filed on 7/25/25 regarding a resident who had waited two hours to have her call light answered. The Assistant Director on Nursing indicated the Education/In-Service record, dated 8/5/25, indicated the education included when to provide Activities of Daily Living (ADLs) care and honoring resident's preferences. The Assistant Director of Nursing indicated the Education/In-service Record had not specifically listed an education and instructions regarding answering call lights in a timely manner. On 9/17/25 from 12:00 P.M. to 1:08 P.M., during a facility tour, resident interviews were conducted throughout the facility. The interviews indicated the following: On the [NAME] Unit, Resident C indicated she had to wait over 30 minutes to get help after she had pressed her call light. She indicated it often took longer than 30 minutes and it had frustrated her because she had not wanted to wet herself but has had no choice. She indicated staff had not asked her if she had concerns about anything, because she would have told them she has concerns about the call lights not being answered timely. Resident D indicated staff were terrible about answering call lights. She indicated she had waited over an hour for someone to answer the light and then staff sometimes turned the light off and had not helped her to the bathroom. She indicated this had been an ongoing problem and she had filed a grievance. On the St. Paul's Unit, Resident E, indicated there was a serious concern with her call light not being answered in a timely manner. Resident E indicated she normally waited 1 1/2 hours to 2 hours for help. The resident indicated that she ended up wetting herself and she had become very uncomfortable and indicated she felt embarrassed. The resident indicated that it was just not right to make a person wait so long for help. Resident E indicated she had filed grievances for having to wait so long for help, but no one had addressed the concern with her. On the St. Joseph's Unit, Resident F indicated she waited over an hour for help. Resident G indicated she had filed grievances about the long wait for her call light to be answered, but nothing had improved and no one had talked to her about her grievances. The</p>		