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 03/13/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure wound treatment orders were obtained timely and wound treatments were completed and signed out as ordered for 2 of 2 residents reviewed for non-pressure related skin conditions. (Residents B and C)Findings Include:1.Resident B's record was reviewed on 3/12/26 at 10:00 a.m. The diagnoses included, but were not limited to, diabetes, atrial fibrillation, high blood pressure, and GERD.The admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact for daily decision making. The resident had a surgical wound prior to admission.A Care Plan, dated 2/5/26, indicated the resident had alteration in skin integrity related to an incision of the scrotal and perineal area. Approaches were to provide treatments as ordered, monitor for pain, and observe for signs/symptoms of infection and notify physician of any abnormal findings.A Physician's Order, dated 2/5/26, indicated to apply vacuum assisted closure dressing with white foam, with a Negative Pressure Wound Therapy (NPWT) dressing to the scrotal/perineal area. Wound vac to be changed every 48-72 hours.A Nurse's Note, dated 2/6/26 at 2:19 p.m., indicated the resident was offsite for a wound vac placement.The Treatment Administration Record (TAR) did not have a wound order signed out for 2/5/26.During an interview on 3/12/26 at 9:33 a.m., the Director of Nursing (DON) indicated she was Resident B's guardian angel. Resident B had come from the hospital with a surgical wound to his testes. The hospital had removed the wound vac prior to him being admitted to their facility. She indicated she personally tried to apply the wound vac and had no success after multiple attempts and interventions. She had called the hospital and the wound nurse reported to her that it took three people and three hours to get the resident's wound vac on. She indicated she made an appointment for wound clinic right away and accompanied the resident the next day to wound clinic. They wound vac was eventually discontinued a couple days later due to the inability to get a seal. At 12:22 p.m., the DON indicated she took off the wet to dry dressing the resident came to their facility with and she had tried to apply the wound vac. When the wound vac was unsuccessful, she did not call to get a new order. She packed the wound with wet to dry gauze and placed an adaptic dressing over it. 2. On 3/13/26 at 10:38 a.m., a wound treatment was observed on Resident C. Wound treatment began at 10:41 a.m. with RN 1 removing the previous foam dressing that was dated 3/12/26. RN 1 stated Don't look, that is the wrong dressing on the wound. Resident C's record was reviewed on 3/13/26 at 10:30 a.m. The diagnoses included, but were not limited to, non-pressure ulcer of the left foot, heart failure, anemia (low iron), and restless leg syndrome.The Initial Minimum Data Set (MDS) assessment, dated 3/10/26 had been initiated but there was no additional information.A Physician's Note, on 3/10/26 indicated the resident was alert and oriented x 3 and had a normal cognitive status. The plan was to continue current medications and orders.A Care Plan, dated 3/10/26, indicated the resident had alteration in skin integrity to the left foot. Approaches were to complete treatments as ordered, observe for signs/symptoms of infection, and assess impaired area weekly and document per protocol.A Physician's Order, dated 3/11/26, and scheduled to begin on 3/12/26, indicated treatment for left plantar foot was lodoform packing strip to the wound bed, apply a betadine-soaked gauze, dry 4x4 gauze pad, and then wrap with kerlix gauze, and then wrap with an ace bandage.The Treatment (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: 155506	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Record (TAR) indicated the order for the left plantar foot had been signed out as completed on 3/12/26.During an interview on 3/13/26 at 12:15 a.m., the Director of Nursing indicated she understood the concerns with the wound treatment and the signed out treatment that was not followed.This citation relates to Intake 2784366410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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 03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were implemented regarding glove change and hand hygiene during a dressing change. In addition, the facility failed to ensure nursing staff understood the required protective equipment needed to care for a resident requiring Enhanced Barrier Precautions for 1 of 2 resident's reviewed for non-pressure skin conditions. (Resident C)Findings include:On 3/13/26 at 10:38 a.m., a wound treatment was observed on Resident C. Wound treatment began at 10:41 a.m. with RN 1 removing the previous foam dressing that was dated 3/12/26. RN1 removed his gloves and left the room to clarify treatment orders. At 10:45 a.m., RN 1 returned with the Nurse Practitioner (NP) and she assessed the wound and agreed that the wound did not require packing and that it was healing great. She gave new verbal orders to RN 1 to clean with a gauze pad soaked with betadine, apply a 4x4 to the wound bed and wrap with kerlix.RN 1, donned gloves and proceeded to cleanse the wound with a soaked betadine pad. After he had completed the wound cleansing and had covered the wound with a clean gauze pad, RN 1 began to unroll the Kerlix gauze (a large gauze roll that is typically used to wrap/secure dressings on body parts) and realized he did not have any tape to secure the dressing. He set the Kerlix gauze roll down and began rummaging through Resident C's side dresser drawers, with his gloved hands, to see if any tape had been left behind. He was unsuccessful in locating any tape, so he returned to the kerlix roll and began dressing the wound again. There was no hand hygiene or glove change after RN 1 looked in the resident's dresser drawers. Once the left foot was wrapped in Kerlix RN 1, doffed Personal Protective Equipment (PPE) and went in search of tape.At 9:49 a.m., RN 1 appeared at resident C's doorway and asked, Is applying tape gown worthy? RN 1 eventually decided to put on the PPE (patient protective equipment), and tape was applied to the resident's kerlix dressing.During an interview at the time, RN 1 indicated he was not sure if he needed to put a gown on if he was just going to apply tape to the top of the dressing. Resident C's record was reviewed on 3/13/26 at 10:30 a.m. The diagnoses included, but were not limited to, non-pressure ulcer of the left foot, heart failure, anemia (low iron), and restless leg syndrome.The Initial Minimum Data Set (MDS) assessment dated [DATE] had been initiated but no additional information had been completed.A Physician's Note, on 3/10/26 indicated the resident was alert and oriented x 3 and had a normal cognitive status. The plan of care was to continue current medications and orders.A Care Plan, dated 3/10/26, indicated the resident had alteration in skin integrity related to left foot. Approaches were to complete treatments as ordered, observe for signs/symptoms of infection, and assess impaired area weekly and document per protocol.During an interview on 3/13/26 at 12:15 a.m., with the Director of Nursing indicated she understood the concerns with the wound treatment as the nurse should have changed his gloves after searching for tape.This citation relates to Intake 2784366410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)