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	05/15/2026

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. Based on interview and record review, the facility failed to assess a resident who had fallen for 1 of 3 residents who were reviewed. (Resident G)Finding includes:During an interview on 5/15/2026 at 10:00 A.M., Resident G indicated she had fallen about a month prior when a staff member had moved her with the Hoyer lift by themselves. Resident G indicated she had not been injured during the fall. Resident G denied have been assessed by a staff member before she was lifted off the floor and back into her bed. She also denied having been assessed by staff after she was put back into her bed. Resident G's record review was complete on 5/15/2026 at 11:00 A.M. Diagnoses included, but were not limited to: type two diabetes mellitus, chronic kidney disease, obesity and major depressive disorder. An Annual Minimum Data Set assessment, dated 3/9/2026, indicated Resident G had moderate cognitive impairment and had been dependent on staff for transfers.A Rehabilitation Evaluation assessment, completed on 3/8/2026, indicated it was appropriate for Resident G to be transferred with a Hoyer lift. Resident G's record lacked the documentation to indicate the resident had been assessed by a staff member after she had fallen. During an interview on 5/15/2026 at 9:30 A.M., the Director of Nursing (DON) indicated there had been an incident when Resident G had been in the process of being transferred with a lift by CNA 2 on 4/13/2026. The resident had been assisted to the floor during the transfer because the resident had been falling out of the mechanical lift transfer sling. CNA 2 had been sent home on 4/13/2026. An investigation into the incident had been started. During the facility's investigation it was determined that CNA 2 had moved Resident G with a mechanical lift, but had not had the assistance of another staff member. The DON indicated the resident's medical record lacked documentation that an assessment had been completed after the fall. The DON indicated after a fall, an assessment of the resident's condition should have been completed and documented by the nurse who was assigned to the resident. On 5/15/2026 at 10:30 A.M., the DON provided a policy, dated 11/2022, and titled, Safe Lifting/ Handling/ Repositioning of Residents. The DON identified the policy as the one currently used by the facility. The policy indicated, .3. A falling resident is to be assisted to the floor, made comfortable and instructed to remain on the floor until licensed nurse/designee evaluates the resident .This deficiency relates to Intake 2967200.410 Indiana Administrative Code 16.2-3.1-37

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
	155506	A. Building B. Wing	05/15/2026

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

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to transfer a resident appropriately resulting in the resident falling for 1 of 3 residents reviewed for falls. (Resident G)Finding includes:During an interview on 5/15/2026 at 9:30 A.M., the Director of Nursing (DON) indicated there had been an incident when Resident G had been in the process of being transferred with a lift by CNA 2 on 4/13/2026. The resident had been assisted to the floor during the transfer because the resident had been falling out of the mechanical lift transfer sling. CNA 2 had been sent home on 4/13/2026. An investigation into the incident had been started. During the facility's investigation it was determined that CNA 2 had moved Resident G with a mechanical lift, but had not had the assistance of another staff member. The DON indicated all mechanical lifts required the assistance of two staff members. CNA 2 was terminated on 4/15/2026 for not following the facility's policy related to transferring residents with a mechanical lift. During an interview on 5/15/2026 at 10:00 A.M., Resident G indicated she had fallen about a month prior when a staff member moved her with the Hoyer lift by themselves. Resident G indicated she had not been injured in the fall. Resident G denied being moved any other time with the Hoyer lift when only one staff member had been present. Resident G's record review was complete on 5/15/2026 at 11:00 A.M. Diagnoses included, but were not limited to: type two diabetes mellitus, chronic kidney disease, obesity and major depressive disorder. An Annual Minimum Data Set assessment, dated 3/9/2026, indicated Resident G had moderate cognitive impairment and had been dependent on staff for transfers. A Rehabilitation Evaluation assessment, completed on 3/8/2026, indicated it had been appropriate for Resident G to be transferred with a Hoyer lift. On 5/15/2026 at 10:30 A.M., the DON provided a policy, dated 11/2022, and titled, Safe Lifting/ Handling/ Repositioning of Residents. The DON identified the policy as the one currently used by the facility. The policy indicated, .2. Associates will not lift or reposition residents in which the individual staff would bear more than 35 pounds of the resident's weight, the National Institute of Occupational Safety and Health safe lifting limit, without the use of appropriate mechanical devices or with the appropriate number of qualified associates/caregivers .This deficiency relates to Intake 2967200.410 Indiana Administrative Code 16.2-3.1-45 (a)