STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155745	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Cross Village at Notre Dame Inc	54515 Sr 933 N Notre Dame, IN 46556

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview the facility failed to update a care plan timely for a resident that acquired a new pressure ulcer for 1 of 15 residents whose care plans were reviewed. (Resident 8)Finding includes:A record review was completed on 4/30/2026 at 2:01 P.M. for Resident 8. Diagnoses included, but were not limited to, multiple sclerosis, dementia and protein calorie malnutrition.A Quarterly Minimum Data Set (MDS) assessment, dated 3/23/2026, indicated Resident 8 had a severe cognitive deficit, was dependent for bed mobility and transfers, was always incontinent of bowel and bladder and had an unstageable pressure ulcer.Review of Nursing Progress Notes indicated a pressure ulcer was first documented on 7/17/2025.However, review of a Care Plan Problem for a sacral pressure ulcer was not initiated until 8/25/2025.During an interview on 5/4/2026 at 11:03 A.M., the ADON indicated the pressure ulcer had first been identified on 7/17/2025 but the care plan had not been updated until 8/25/2025.A policy for updating Care Plans was requested, on 5/4/2026 at 11:15 A.M., but one was not provided before the survey exit.3.1-35(d)(2)(B)

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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure 1 of 2 nursing staff (Qualified Medication Aide 2) administering medications demonstrastrated competence.Finding includes:During an observation on 5/4/2026 at 9:50 A.M., Resident 6 indicated a cup of clear liquid sitting at the bedside contained his laxative (polyethylene glycol) that he had not finished yet. During an interview on 5/4/2026 at 10:09 A.M., Qualified Medication [NAME] (QMA) 2 indicated she had administered morning medications to Resident 6 and had left the polyethylene glycol medication, which had been dissolved in water, at his bedside. She indicated she should have made sure he had taken all of the medication before leaving the resident's room.A record review for Resident 6 completed on 4/30/2026 at 11:08 A.M. indicated a Physician's Order for polyethylene glycol 17 grams by mouth dissolved in 4-8 ounces of a fluid of choice once a day. The order had been initiated on 12/17/2025.A current policy, revised 8/2025 and titled, Medication Administration Policy was provided by the DON on 5/4/2026 at 11:25 A.M. The policy indicated, .observe resident consumption of medication 3.1-14(i)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview the facility failed to monitor medications for 2 of 6 residents whose medications were reviewed. (Residents 4 and 1)1. A record review was completed on 5/1/2026 at 9:01 A.M. for Resident 4. Diagnoses included, but were not limited to type 2 diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 3/17/2026, indicated Resident 4 received daily insulin injections. Physician Orders included, but were not limited to, the following: -dated 4/6/2026 Insulin Glargine Subcutaneous Solution Pen-injector 100 units/milliliter inject 20 units subcutaneously in the evening for diabetes mellitus. -dated 8/12/2025 HA1C (glycated hemoglobin test- a blood test that measures average blood sugar levels over the past 2-3 months) every 6 months. Review of the clinical record indicated a HA1C lab test had not been completed until 3/20/2026. During an interview on 5/4/2026 at 11:15 A.M. the ADON indicated the HA1C should have been done on 2/12/2026 but had not been completed until 3/20/2026. 2. Resident 1's record review was completed on 5/1/2026 at 10:00 A.M Diagnoses included but were not limited to: chronic heart failure, hypertension, atrial firbrilation, localized edema of lower extremities, osteoarthritis, bilateral hearing loss, nonrheumatic mitral valve insufficiency and major depression disorder. A current Physician's order, dated 2/10/2026, indicated Resident 1 was to receive 40 mg (milligrams) of furosemide (a diuretic water pill) once a day for edema. A Quarterly Minimum Data Set (MDS) assessment, completed on 3/13/2026, indicated Resident 1 had been administered a diuretic (water pill) daily. A Physician's order, dated 4/28/2026, indicated Resident 1 was scheduled to be administered 20 mg of furosemide daily. The resident had also received an additional 40 mgs of furosemide from 4/28-5/1/2028 for edema. A current Physician's order dated, 5/13/2024. indicated Resident 1 was to have her weight assessed on Tuesdays and Fridays to monitor for weight gain and the Physician was to be notified if the resident had a weight gain of five pounds since her previous weight assessment. A current Care Plan initiated on 9/22/2023, and revised on 12/11/2024, indicated Resident 1 had experienced alterations in her cardiovascular status related to hypertension, atrial fibrillation and heart failure. An intervention, initiated on 9/22/2023, indicated the resident's weight was to be monitored, recorded in the Electronic Medical Record and the provider notified of changes in weight. A review of Resident 1's February 2026 Treatment Administration Record (TAR) indicated Resident 1 had not been weighed on 2/6, 2/13, or 2/20/2026. There was no weight refusal documentations either (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the February missed weights. A review of Resident 1's March 2026 TAR indicated Resident 1 had not been weighed on 3/3, 3/13, 3/17, 3/20, 3/24, 3/27 or 3/31/2026. Again, there was no documentation that Resident 1 had refused to be weighed. On 5/5/2026 at 10:00 A.M, the DON provided a policy dated 8/2025, titled, Medication Administration. The DON identified the policy as the one currently used by the facility for all Physician orders, including treatments. The policy indicated, .9. Review MAR to identify medication to be administered. 10. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time There was no specific policy regarding weighing residents and notifying the physician of weight changes provided. 410 Indiana Administrative Code (IAC) 16.2-3.1-48 (a)(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure documentation regarding incidents that had occurred in the facility were included in the resident's Electronic Medical Record for 2 of 2 resident's reviewed for accidents. (Residents 43 and 1)Findings include:1. During an interview on 4/29/2026 at 12:08 P.M. with Resident 43's daughter, she indicated Resident 43 was no longer able to leave the secure unit due to his increased agitation, decreased sleeping, wandering into other residents rooms and leaving the facility. During an observation of Resident 43, on 4/29/2026 at 12:10 P.M., Resident 43 was noted to be wearing a wanderguard (monitor that alarms if resident stands close to exit doors) on his ankle. Resident 43's record review was completed on 4/30/2026 at 3:00 P.M. Diagnoses included, but were not limited to: dementia, hypertension, glaucoma and adjustment disorder with anxiety. An admission Minimum Data Set (MDS) assessment, completed on 4/2/2026, indicated the resident had intact cognition, had usually been able to understand others and had been able to make himself understood. Resident 1 had not displayed any behaviors, had not rejected any care and was not documented as having utilized any wanderguard device. A Nursing Progress note, dated 4/28/2026 at 9:44 A.M., indicated the following: Therapy staff came to the unit, and stated, 'pretty sure they had seen Resident 43 walking down the hallway. The nurse had gone to investigate the situation and Resident 1 had been observed standing by the dining room. Resident 43 had been confused and only stated, he was 'Trying to get out of here.Review of therapy staff statements, on 5/1/2026 at 9:30 A.M., provided by the Director of Nursing, regarding Resident 43's incident on 4/28/2026, indicated a therapy staff member had observed Resident 43 exit his resident room window and walk onto the facility grounds outside the building. The Therapy staff member relayed the information to another Therapy staff member. The second Therapy staff member then exited the building and assisted Resident 43 back into the building and alerted the nursing staff.An Elopement Risk assessment, completed on 3/29/2026, indicated Resident 43 had received a score of 3- indicating he was a risk for elopement. A current Physician's order, initiated on 4/26/2026, indicated Resident 43's wanderguard's placement was to be checked every shift. During an interview with the Director of Dementia Care (DDC), on 5/1/2026 at 10:00 A.M., the DDC indicated Resident 43 had left the faciity on 4/28/2026. The resident had removed the screens from the windows in his room and had pushed the windows out. The DDC indicated the resident had been observed outside by the Therapy Department, and a therapist had went outside and had brought the resident back into the building. The DDC indicated this was not the first time the resident had left the facility. The DDC indicated there was no documentation in Resident 43's EMR regarding the resident's exit from the building on 4/28/2026. It was unclear why the nursing note on 4/28/2026 indicated the resident had been found in a dining room area when, in fact, he had exited his room and the building through a window and had been observed on outside on the facility grounds, and had been brought back inside the building by a therapy staff member.During an interview on 5/1/2026 at 10:30 A.M., the Director of Nursing indicated a Therapy staff member had seen Resident 43 push his window out and exit the building. The staff member had gone outside and assisted him back into the facility and had notified the nursing unit. The DON indicated the Therapist's statements were not in the EMR and she was unable to indicate why the therapist's notes or an accurate description of the event was not documented in the record. A review of the Resident 43's chart was reviewed again on 5/6/2026 at 9:05 A.M. The record remained unchanged and continued to reflect an inaccurate description of the events for Resident 43 which had occurred on 4/28/2026. On 5/6/2026 at 9:10 A.M., a copy of the Therapist's written statements from both Therapists who witnessed Resident 43 outside were requested and not provided.On 5/6/2026 at 11:50 A.M., a copy of the Therapist's written statement from both Therapists who witnessed Resident 43 outside were requested again, but were not received before the survey exit. 2. During an interview on 5/1/2026 at 11:00 A.M., Resident 1's husband (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated he shared a room with his wife at the facility and last night, during Resident 1's shower, she had been injured and had a hematoma on her right shin. Resident 1's husband indicated his wife had been screaming out in pain and stating, this is worse than childbirth. Resident 1 indicated he had pushed the call light and called the Unit Manager's office but had not been able to get staff to respond. Resident 1's husband indicated he had waited for help for thirty minutes and then he had called 911 and requested an ambulance. Resident 1's record review was completed on 5/1/2026 at 11:00 A.M Diagnoses included but were not limited to: chronic heart failure, hypertension, atrial fibrillation, localized edema of lower extremities, osteoarthritis, bilateral hearing loss, nonrheumatic mitral valve insufficiency and major depression disorder. A Quarterly Minimum Data Set (MDS) assessment, completed on 3/13/2026, indicated Resident 1 had minimal difficulty hearing, had clear speech, had been able to make herself understood and usually understood others. The resident did not have any cognitive impairment and was not documented as having had any behaviors or rejection of care issues.A Nursing Progress note completed on 4/30/2026 at 11:39 P.M., indicated while showering, Resident 1 had knocked a bottle of body wash over, causing the bottle to fall onto her right shin which had caused a hematoma. An ice pack was applied to the area and the on-call management staff had been notified. A Nursing Progress note, completed on 5/1/2026 at 9:46 A.M., indicated Resident 1 was complaining of excruciating pain to her right lower leg and had requested to be sent to the hospital. During an interview on 5/1/2026 at 11:10 A.M., CNA 3 indicated he had not heard Resident 1 calling out in pain nor had he observed the call light on prior to Resident 1's husband's 911 call. CNA 3 indicated he had last seen Resident 1 and her husband thirty minutes before 911 was called and Resident 1 had complained of pain in her leg at the time. CNA 3 indicated he had notified LPN 4 of Resident 1's pain. During an interview on 5/1/2026 at 11:13 A.M., LPN 4 indicated she had been alerted by CNA 3 that Resident 1 was in pain. LPN 4 indicated she had assessed Resident 1's leg pain and the resident had rated her pain at a 4 out of 10 (0 being no pain and 10 being the worst pain) LPN 4 indicated she had left the room to notify the provider of the resident's pain and had not observed the resident's call light on after she had exited. LPN 4 indicated the resident had not requested to be sent to the Emergency Department by facility staff but Resident 1's husband had called 911. LPN 4 indicated the documentation had not included information indicating the resident's husband had called 911. During an interview with Director of Nursing (DON) on 5/1/2026 at 1:00 P.M., she indicated the documentation in Resident 1's EMR had not accurately represented the situation that had happened with Resident 1 on 5/1/2026, and whomever read the Nursing note associated with the resident being sent to the Emergency Department, would likely believe the facility had sent the resident out for treatment and would not know the resident's husband had actually called 911.Resident 1's chart was reviewed again on 5/6/2026 at 9:00 A.M. There had been no documentation added to Resident 1's EMR to indicate the facility had not sent her to the Emergency Department, and her husband had been responsible for calling 911 in order to have Resident 1 transferred to the Emergency Department. On 5/1/2026 at 1:45 P.M., the DON provided a policy dated 2/2026 and titled, Documentation Policy. The DON indicated the policy was the one currently used by the facility. The policy indicated, .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . 1/ Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 6. Corrections to a medical record shall be made to clarify inaccurate information. 410 Indiana Administrative Code 16.2-3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to maintain enhanced barrier precautions during the administration of a tube feeding for 1 of 1 residents observed receiving gastrostomy tube care. (Resident 6) Finding includes: During an observation on 5/4/2026 at 9:50 A.M., LPN 5 administered a g-tube feeding. She wore gloves but had not donned a gown. There was a sign on Resident 6's room door indicating Resident 6 was in Enhanced Barrier Isolation. A record review was completed on 4/30/2026 at 11:08 A.M. for Resident 6. Diagnoses included, but were not limited to, Parkinson's Disease and dysphagia (difficulty swallowing). A Quarterly Minimum Data Set (MDS) assessment, dated 3/31/2026, indicated Resident 6 had intact cognition, had a g-tube (gastrostomy tube inserted into the stomach to administer food and nutrition) for tube feedings and had not experienced significant weight loss. Physician Orders for Resident 6 included, but were not limited to, the following:-3/13/2026 NPO (nothing by mouth)-10/17/2026 additional water flush of 100 ml (milliliters) per g-tube three times a day to provide additional free water for hydration.-4/27/2026 Jevity 1.5 via g-tube 300ml bolus four times a day to provide 1800 total calories for nutrition. A Care Plan, dated 9/8/2025, indicated the need for g-tube feedings related to refusal to eat and swallow study results. During an interview on 5/4/2026 at 9:58 A.M., LPN 5 indicated she should have worn a gown during the g-tube feeding administration but had not known where they were kept. She further indicated she should have asked where the gowns were stored. She indicated she had completed training on the computer for Enhanced Barrier Precautions. On 5/4/2026 a current policy, revised 4/2024 and titled, Enhanced Barrier Precautions was provided by the DON. The policy indicated, .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. and .High contact resident care activities can include any of the following: Device care or use: central lines, urinary catheters, feeding tubes 3.1-18(2)(b)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to provide a timely consented pneumococcal immunization for 1 of 5 residents reviewed for infection control. (Resident 29) Finding includes:A record review for Resident 29, completed on 4/29/2026 at 2:12 P.M., indicated Resident 29's Power of Attorney (POA) consented, on 9/12/2025, for a pneumococcal vaccination and a COVID-19 booster to be administered.A Physician's Order, dated 3/30/2026, indicated Prevenar 20 (Pneumococcal 20-Valent Conjugate Vaccine) intramuscular 0.5 milliliter every day for disease prevention for one day on 4/8/2026.A Physician's Order, dated 4/29/2026, indicated Prevenar 20 (Pneumococcal 20-Valent Conjugate Vaccine) intramuscular 0.5 milliliter every day for disease prevention for one day on 4/29/2026.A Medication Administration Record, dated 4/2026, indicated on 4/8/2026, the Prevenar 20 had been spit out with administration and had not been administered until 4/29/2026.During an interview, on 5/4/2026 at 11:03 A.M., the Infection Preventionist indicated all consented vaccinations should be completed within 30 days of the consent. She indicated it would have been an unusual occurrence should a vaccination not be given until 5-6 months after the consent had been signed. She indicated there had been some confusion regarding the administration of the vaccination as Resident 29 had been receiving hospice services and the Qualified Medication Assistant (QMA) had documented an error when the Prevenar injection had been scheduled to be given on 4/8/2026.A policy was provided, on 4/29/2026 at 3:05 P.M., by the Director of Nursing. The policy titled, Pneumococcal Vaccine, indicated, .It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC [Center for Disease Control] guidelines and recommendations.2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved ?standing orders'.7. A pneumococcal vaccination is recommended for all adults 65 years ?and older.410 IAC (Indiana Administrative Code) 16.2-3.1-13(a)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to provide a timely COVID-19 immunization for 1 of 5 residents reviewed for infection control. (Resident 29) Finding includes:A record review for Resident 29, on 4/29/2026 at 2:12 P.M., indicated Resident 29's Power of Attorney (POA) had consented, on 9/12/2025, for the COVID-19 booster to be administered.A Physician's Order, dated 3/30/2026, indicated (COVID-19 9SARS-CoV-2) mRNA Virus Vaccine 0.3 milliliters intramuscularly every day for disease prevention for one day on 4/1/2026.A Medication Administration Record, dated 4/2026, indicated the COVID-19 immunization had not been administered on 4/1/2026.A Physician's Order, dated 4/29/2026, indicated (COVID-19 9SARS-CoV-2) mRNA Virus Vaccine 0.3 milliliters intramuscularly every day for disease prevention for one day on 5/1/2026.A Medication Administration Record, dated 5/2026, indicated the COVID-19 immunization had not been administered on 5/1/2026.During an interview, on 5/4/2026 at 11:03 A.M., the Infection Preventionist indicated all consented vaccinations should be completed within 30 days of consent. She indicated it would have been an unusual occurrence should a vaccination be given 5-6 months after a consent had been signed. She indicted there had been some confusion regarding Resident 29's COVID-19 vaccination because the resident was receiving hospice services.A policy was requested during the entrance conference for the COVID-19 immunization policy, on 4/29/2026 at 9:48 A.M. A policy was not provided prior to the survey exit.410 IAC (Indiana Administrative Code) 16.2-3.1-13(a)