

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000104	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2014
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NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00143913.</p> <p>Complaint IN00143913-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: March 5, 2014</p> <p>Facility number: 000104 Provider number: 155197 AIM number: 100266590</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF: 11 SNF/NF: 60 Residential: 105 Total: 176</p> <p>Census payor type: Medicare: 13 Medicaid: 57 Other: 106 Total: 176</p> <p>Sample: 3</p> <p>Sanctuary at St. Pauls was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the Investigation of Complaint IN00143913.</p> <p>Quality Review completed on March 7, 2014, by Brenda Meredith, R.N.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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