

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
F 0000  Bldg. 00	<p>This survey was for the Investigation of Complaints IN00199984 and IN00201174.</p> <p>Complaint IN00199984 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F333.</p> <p>Complaint IN00201174 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.</p> <p>Survey dates: May 23, 24, 25 &amp; 26, 2016</p> <p>Facility number: 001201 Provider number: 155506 AIM number: 100380860</p> <p>Census bed type: SNF: 45 SNF/NF: 80 Total: 125</p> <p>Census bed type: Medicare: 26 Medicaid: 62 Other: 37 Total: 125</p> <p>Sample: 5</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
F 0309 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on June 3, 2016.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure weights were consistently monitored for 1 resident, who incurred a weight change, in a sample of 5 residents reviewed for assessments. (Resident "B")</p> <p>Finding includes:</p> <p>The record of Resident "B" was reviewed on 05/23/16 at 10:11 a.m. Resident "B" was admitted to the facility on 02/16/16. The diagnoses included, but were not</p>	F 0309	F-309 It is the intent of Sanctuary at Holy Cross to provide care and services for highest wellbeing. 1. Resident "B" no longer resides at the facility. 2. An audit was completed with no other daily weight orders. Audit expanded to include all weights ensuring weight variance notifications provided to the physician. 3. Re-education of nursing staff regarding following physician orders including but not limited to weight orders and notification of physician with variances conducted by Director of Nursing. 4. Five times a week audit will be completed by nursing leadership	06/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>limited to, Stage 3 CKD (Chronic Kidney Disease), acute cholecystitis (acute gallbladder inflammation), sepsis secondary to streptococcal bacteremia, cirrhosis with secondary ascites, DMII (Diabetes Mellitus), CHF (Congestive Heart Failure), A-fib (Atrial Fibrillation: irregular heart rate), pacemaker, patchy (L) (Left) lung base/developing pneumonia, edema, HTN (Hypertension), chronic proctosigmoiditis (chronic inflammation of the bowel) and BPH (Benign Prostate Hypertrophy: enlarged prostate). During hospitalization, the resident had a paracentesis with 2.5 liters of ascitic fluid removed. The resident had a pre-existing history of chronic loose stools.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 02/23/16, indicated Resident "B" was cognitively intact and required extensive assistance of 2 for transfers and toileting. Resident "B" expired, in the facility, on 03/14/16.</p> <p>The "Physician Order Sheet", dated 02/2016, indicated: "02/19/16 Daily weights, notify [Physician's name] if weight increases more than 5 pounds...CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE."</p>		<p>team for following of physicianorders and notification of variances related to physician orders. Audits willbe reported up to Mission Drive Quality Improvement Committee by the Directorof Nursing for 6 months then Committee will determine need for furthermonitoring.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>The record indicated daily weight were completed on 5 of the 25 days following the written order. Resident "B" weighed 204 lbs (pounds) on admission. Weights: "02/19/16: 200.4" "02/20/16: 199.4" "02/24/16: 190.8" "03/07/16: 187.2" "03/10/16: 186.4"</p> <p>Resident "B" had incurred a 17.6 lb from admission to the last recorded weight. The resident's weight between 03/10/16 and death on 03/14/16 was unknown.</p> <p>A dietician note, dated 02/29/16, indicated: "14 day Nutrition Review...: Weekly weight 190.4 lbs [pounds], weight down 6.6% [percent] since admission, planned significant weight decline with resolution of edema...Continue to monitor weights, and diet acceptance."</p> <p>A dietician note, dated 03/06/16, indicated: "RN [Registered Nurse] notified RD [Registered Dietician] that guest [Resident #B] has been having diarrhea and poor appetite...weight loss anticipated r/t [related/to] edema/fluid loss. Guest c [with] chronic colitis...Ensure Clear QID [four times a day] for hydration and nutrition support. Will follow up as needed..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
F 0333 SS=D	<p>The "Clinical Notes" indicated the resident had loose stools and was to receive routine medication as well as PRN (as needed) medications for loose stools. There was no indication the physician or FNP (Family Nurse Practitioner) was made aware of the continued weight loss.</p> <p>The "Physician Progress Notes," dated 03/02/16, 03/07/16 and 03/14/16, did not indicate the physician was aware of the continued weight loss.</p> <p>During the survey, a confidential interview, indicated Resident "B" appeared emaciated, had poor skin turgor and his eyes appeared "sunken."</p> <p>This Federal tag relates to Complaint IN00199984.</p> <p>3.1-37(a)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
Bldg. 00	<p><b>ERRORS</b></p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident with chronic loose stools received an anti-diarrheal medication as ordered. This deficiency affected 1 of 5 residents reviewed for medication administration. (Resident "B")</p> <p>Finding includes:</p> <p>The record of Resident "B" was reviewed on 05/23/16 at 10:11 a.m. Resident "B" was admitted to the facility, on 02/16/16, with diagnoses which included, but were not limited to, Stage 3 CKD (Chronic Kidney Disease), acute cholecystitis (acute gallbladder inflammation, sepsis secondary to streptococcal bacteremia, cirrhosis with secondary ascites, DMII (Diabetes Mellitus), CHF (Congestive Heart Failure), A-fib (Atrial Fibrillation: irregular heart rate), pacemaker, patchy (L) (Left) lung base/developing pneumonia, edema, HTN (Hypertension), chronic proctosigmoiditis (chronic inflammation of the bowel) and BPH (Benign Prostate Hypertrophy: enlarged prostate). The resident had a pre-existing history of chronic loose stools and was an established patient prior to admission with a Gastroenterologist (GI) Physician.</p>	F 0333	<p>F-333. It is the intent of Sanctuary at Holy Cross to ensure that residents are free of any significant medication errors. 1. Resident "B" no longer resides at the facility. 2. An audit was conducted of medication orders for timeliness of implementation. 3. Re-education of the licensed nursing staff by the Director of Nursing in regards to implementation of physician orders. 4. Five times a week audits of physician orders for timely implementation of the orders by the CCC. Audits will be reported up to Mission Driven Quality Improvement Committee by the Director of Nursing monthly times 6 then committee will determine need for further monitoring.</p>	06/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>Resident "B" expired, in the facility, on 03/14/16.</p> <p>Resident "B" continued to have loose stools throughout his facility stay. A review of the "Physicians Order Sheet" indicated:</p> <p>"02/24/16 ANTI-DIARRHEAL [immodium] 2 mg [milligram] TABLET Oral-16 mg per 24 hour period-Dx [diagnosis] Loose stools...As needed [PRN] eight times Max [Maximum] starting 02/24/16. [FNP name: Family Nurse Practitioner]"</p> <p>"02/29/16 LOPERAMIDE [immodium] 2 mg Oral. loose stools...As Needed Eight Times Max starting 02/29/16. [FNP name]"</p> <p>Review of the MARs (Medication Administration Record), for 02/2016 and 03/2016, indicated Resident "B" received the PRN Anti-Diarrheal medication: 02/26/16: 1 time 02/27/16: 1 time 02/28/16: 1 time 03/03/16 thru 03/13/16 (10 days): total of 13 doses.</p> <p>Resident "B" was taken by a family member to the office of his GI physician for related diagnoses on 03/10/16. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>resident was returned to the facility with a prescription: "1. Take lomotil [anti-diarrheal]1 po [per os: by mouth] tid [three times daily]...."</p> <p>Review of the "Physician's Order Sheet" indicated: "03/14/16 LOMOTIL 2.5 - 0.025 mg (1 tab) TABLET Oral for diarrhea to be started when it arrives in the building...Three Times Daily...6:00 a.m. 2:00 p.m. 10:00 p.m....[FNP name]."</p> <p>The 03/2016 MAR indicated Resident "B" received the 1st and only dose of Lomotil on 03/14/16. The resident missed a minimum of 10 doses of lomotil.</p> <p>The Administrator was interviewed on 05/25/16 at 10:00 a.m. and indicated the physician's office was contacted to order and clarify the lomotil dosage but did not return the call. The FNP then ordered the medication 4 days later, on 03/14/16.</p> <p>The Administrator was unaware Resident "B" had not received the PRN anti-diarrheal medication routinely as ordered.</p> <p>The DNS (Director of Nursing Services) was interviewed on 05/25/16 at 11:50 a.m. and indicated the GI physician failed to clarify the lomotil dosage with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
F 0441 SS=D Bldg. 00	<p>facility. The DNS indicated the facility should have followed up with the facility physician or FNP to obtain the lomotil dosage when the GI physician did not respond to the facility's request.</p> <p>This Federal tag relates to Complaint IN00199984.</p> <p>3.1-25(b)(9)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record reviews, observations and interviews, the facility failed to ensure isolation precautions were maintained for a resident in with C-diff (Clostridium- Difficile). This deficiency affected 1 of 3 residents observed in a sample of 5 reviewed for infection control. (Resident "E")</p> <p>Finding includes:</p> <p>The record of Resident "E" was reviewed on 05/25/16 at 3:50 p.m. Resident "E" was admitted to the facility, on 04/21/16, with diagnoses which included, but were not limited to, cirrhosis, edema, UTI (Urinary Tract infection) and weakness.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 04/28/16, indicated Resident "E" was cognitively</p>	F 0441	F-441. It is the intent of Sanctuary at Holy Cross to maintain an Infection Control Program to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of disease and infection. 1. Resident "E" admitted on antibiotic therapy for UTI infection developed loose stools and then tested positive for C. difficle. This resident no longer resides at the facility. 2. Audit of residents in isolation process revealed no other deficient practices noted. 3. Re-education of all staff regarding infection control process conducted by the Director of Nursing 4. Random three times a week observation audits conducted for compliance of infection control process will be completed by the infection control nurse then reported to Mission Driven Quality Improvement Committee by the Director of	06/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/26/2016	
NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635			
(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) COMPLETION DATE			
	<p>impaired, and required extensive assistance of 1 for transfers, ambulation, dressing, bathing and toileting.</p> <p>Resident "E" developed loose stools, was placed in isolation and a stool sample for C-diff was obtained on 04/29/16. The test results on 04/30/16 were positive for C-diff.</p> <p>The St Mark's unit was observed on 05/25/16 between 9:50 a.m. and 10:35 a.m. The unit consists of 12 private rooms arranged in 3 pods of 4 rooms each. Staff verbally interacting and/or physically assisting residents included, but were not limited to, housekeeping, Unit CNA (Certified Nursing Assistant), Unit LPN (Licensed Practical Nurse), dietary aides, and PTAs (Physical Therapy Aides).</p> <p>On 05/25/16, Resident "E" was observed resting in bed and had an isolation supply unit outside his door. At 10:13 a.m., PTA #3 was observed putting on gloves and entered the room of Resident "E" and began interacting with the resident, being out of line of vision a short period of time. PTA #3 was then observed standing at the end of the resident's bed with her gloved hands at her waist coming in direct contact with her clothing and gait belt, which was around her</p>		Nursing monthly for 6 months then the committee will determine further need for monitoring.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/26/2016
NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635		
(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) COMPLETION DATE	
	<p>waist, at 10:24 a.m.</p> <p>PTA #3 then exited the room without removing her gloves. PTA #3 was briefly out of visual sight in the common area of the pod and was then observed to have removed her gloves. PTA #3 returned, put on new gloves and entered the room at 10:25 a.m. PTA #3 was not observed nor heard washing her hands before changing her gloves. PTA #3 was observed sitting on the chair in the room of Resident "E" and with her gloved hands demonstrating exercises which were being performed by Resident "E" using a red exercise band. PTA #3 did not have on an isolation gown</p> <p>During an interview on 05/25/16 at 10:00 a.m., CNA #5 indicated residents in isolation for C-diff required gloves and gowns when entering the room to assist or provide care or when coming in contact with resident surfaces in the resident rooms.</p> <p>During an interview on 05/25/16 at 10:50 a.m., LPN #2 indicated residents in isolation for C-diff required gloves and gowns when in a residents room to assist or provide care or coming in contact with resident surfaces in the resident rooms. LPN #2 indicated resident surfaces included, but were not limited to, areas</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>the resident could come in contact with, including bedside tables and chairs.</p> <p>On 05/25/2016, at 1:15 p.m., the DNS (Director Nursing Services) provided the facility's "Infection Control...12/209" Policy &amp; Procedure, and indicated this was the policy &amp; procedure currently used by the facility. The Policy &amp; Procedure indicated:</p> <p>"Contact Precaution: Contact transmission is the most important and frequent mode of transmission of healthcare associated infections...</p> <p>Direct Contact Transmission: A direct body surface-to surface contact and physical transfer of microorganisms between a susceptible host and an infected or colonized person occurs with direct contact transmission.</p> <p>Indirect Contact Transmission: Contact between a susceptible host and a contaminated object is indirect contact transmission.</p> <p>Contact precautions reduce the risk of transmission by either direct or indirect contact.</p> <p>In addition to stand precautions, the following measures are necessary for contact precautions:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635
--	---

(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) COMPLETION DATE
	<p>Wear gloves during the course of providing resident care. Wear gloves when in direct contact with a resident who is infected or colorized with organisms that are transmitted by direct contact... Change gloves after contact with infective material... Remove gloves before leaving the resident's room and immediately wash hands with an antimicrobial agent ... Wear gown only when clothing anticipated to come in contact with the resident, environmental surfaces, or items in room contaminated with organism Remove gown before leaving room and immediately wash hands with an antimicrobial agent... Consider the epidemiology of the microorganism to determine placement."</p> <p>"TYPE AND DURATION OF PRECAUTIONS RECOMMENCED FOR SELECTED INFECTIONS AND CONDITIONS: Infection/Condition C. difficile Type: C [Contact] Duration: DI [Duration Illness] Precautions: Comments...Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/26/2016
NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635		
(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) COMPLETION DATE	
	This Federal tag relates to Complaint IN00201174.  3.1-18(j) 3.1-18(l)				