

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
---	---

(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 visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 1, 2, 3, 4, 5 and 8, 2016</p> <p>Facility number: 000104 Provider number: 155197 AIM number: 100266590</p> <p>Census bed type: SNF: 8 SNF/NF: 57 Residential: 111 Total: 176</p> <p>Census payor type: Medicare: 19 Medicaid: 28 Other: 18 Total: 65</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on February 10, 2016.</p>	F 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Sanctuary At St Paul's respectfully requests the Plan of Correction and supporting documentation be considered for desktop review. We declare date of compliance of March 9, 2016.</p>	

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: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
---	---

(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 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to store, prepare and serve food in a sanitary manner, related to freezer temperatures, food dating, dish storage and food serving, in 1 of 1 kitchens and 2 of 2 dinning rooms.</p> <p>Findings include:</p> <p>1. During the initial kitchen tour on 2-1-16 between 10:20 A.M. and 11:00 A.M., conducted with the DM (Dietary Manager), the following was observed:</p> <p>* On the clean dish storage rack: 50 plates, 40 square plates, and 1 serving bowl, stored upright.</p> <p>* In the ice cream freezer: 1- three gallon container of blue moon, butter pecan, and moose track, ice cream open with no dates. No thermometer was</p>	F 0371	<p>Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will betaken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. District Manager of Culinary Services reviewed and provided additional education of survey findings to Culinary Management Team. Culinary Director or designee will provide an Inservice to all associates in the following departments; Culinary, Nursing, Activities and Facility Management. The Inservice will consist of handwashing, glove use, server etiquette, storage of dishware, handling of dishware, serving of food, labeling & dating</p>	03/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
---	---

(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>found inside the freezer. The DM indicated "...they should be dated...yes it should have a thermometer inside the freezer...."</p> <p>* Ice Machine: On the inside top right corner a black substance was observed. The DM at this time was observed attempting to wipe it off with the apron he was wearing.</p> <p>*In the walk in freezer: A open, undated, box of ragoons. A open, undated box of garden veggie patties. A open to air, undated, box of potpie crust. A open, undated, box of biscuits, breadsticks, pizza, vegetable, and sunflower seed bread dough. A open, undated, box of sausage and bratwurst.</p> <p>2. On 2-1-16 between 11:30 A.M. and 12:15 P.M., during observation of the lunch meal in the 2nd floor dining room the following was observed:</p> <p>At 11:30 A.M., Server #7 was observed picking up a bowl of potatoes and a lunch plate with her thumbs on the inside edge, then served it to a resident.</p> <p>At 11:40 A.M. Server #4 was observed to</p>		<p>of food, storage of food products, refrigeration equipped with thermometers and cleaning of ice machine. The Inservice will include demonstration and return demonstrations for the associates to validate competency with tasks. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Culinary Director or designee to observe daily meal service and complete three random meal service audits weekly. The meal service daily observation and weekly audits will consist of handwashing, glove use, server etiquette, storage of dishware, handling of dishware, serving of food, label & dating of food, storage of food products, refrigeration equipped with thermometers and cleaning of ice machine. The Culinary Director or designee will provide associates with on the spot education as needed during daily observation and weekly audits then submit audits to Administrator or designee for review. Data will be reviewed monthly by Administrator and Culinary Director to identify trends and implement action plans as necessary. Culinary Director or designee to report findings quarterly to the MDQI/QAPI Committee on an ongoing basis. Q5. By what date the systemic</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2016	
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS				STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614			
(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>open a cupboard with her gloved hand, then ladled soup into a bowl, then with same gloved hand leafed through resident menus, then continued to serve food.</p> <p>At 11:43 A.M., the DM was observed washing his hands for 8 seconds, put gloves on, remove sliced cheese from the refrigerator, unwrapped it and place a slice on a hamburger.</p> <p>At 11:44 A.M., the DM was observed washing his hands for 8 seconds, put gloves on then place a bowl of soup in the microwave.</p> <p>At 11:46 A.M., CNA (Certified Nursing Assistant) #8 was observed leaning on her forearms on a table while taking a residents lunch order.</p> <p>At 11:48 A.M., Server #7 was observed serving a lunch plate to a resident with her thumbs on the inside edge of the plate.</p> <p>At 11:49 A.M., the DM was observed washing his hands for 6 seconds, turned off the faucet with his wet hands before drying them.</p> <p>At 11:55 A.M., the DM was observed to wash his hands for 7 seconds, put on gloves then poured a can of soup in a</p>		changes will be completed; A5. March 9, 2016.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
---	---

(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>bowl.</p> <p>At 12:01 P.M., Server #4 was observed with gloves on leafing through resident menus then place meat on bun, then with same gloved hand, placed the top bun on the sandwich.</p> <p>At 12:05 P.M., CNA #8 was observed escorting a resident to the dinning room table, took residents order, got the resident a drink out of the refrigerator, placed ice in a glass, and serve to the resident, with out washing her hands.</p> <p>At 12: 08 P.M., Server #4 was observed to reach to the back of the stove, dragging her shirt sleeve in the roast beef pan,</p> <p>3. On 2/4/16 between 11:30 A.M. and 12:15 P.M., during observation of the lunch meal in the 3rd floor dining room the following was observed:</p> <p>At 11:37 A.M., Server #7 was observed resting a gloved hand on the table while taking a residents lunch order, she then picked up a bowl with her thumb on the inside, poured a can of soup into the bowl, heated it, and served it to the resident.</p> <p>At 11:40 A.M., Server #7 was observed washing her hands for 8 seconds, put on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS	STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614
---	---

(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>gloves, then served two glasses of drinks.</p> <p>At 11:56 A.M., Server #6 was observed to reach in a bag of bread with gloved hands, get two slices of bread out, used tongs to place turkey, lettuce, and tomatoes on the bread, closed the sandwich with gloved hand. She then ladled two bowls soup, placed stuffed peppers and carrots on a plate, put on new gloves without washing her hands, touched menus, plated two more dinners, then removed two slices bread out of bag, picked up lettuce placed on sandwich with gloved hand and used tongs to place tomatoes on sandwich.</p> <p>At 12:05 P.M., Server #7 was observed to wash her hands for 7 seconds, then made and served a peanut butter sandwich to a resident.</p> <p>During an interview on 2-5-16 at 9:47 A.M., the District Manager indicated "...hand washing should be done whenever they change tasks... for 20 seconds... they need to be wearing gloves when ever handling food unless using tongs... cooks should use utensils to touch... if you touch food wash hands and put on new gloves... carry bowls and plates by bottom...servers should be careful to not touch food surfaces... change gloves every time you dirty gloves while</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2016	
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS				STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614			
(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>serving... wash hands and change gloves... any open food needs to have a date and be closed to air... thermometers should be inside of all refrigerators and freezers... the ice machine should not have a black build up on the inside of it and no, you shouldn't clean it off with your apron... clean dishes should be stored upside down...."</p> <p>On 2-8-16 at 10:35 A.M., review of the current policy titled "Hand Washing procedures," dated August 2004 and revised September 2013, provided by the District Manager on 2-8-16 at 9:55 A.M., indicated " Frequency:... Before and after handling food...Before and after working with individuals residents... After engaging in an activities that contaminate the hands... Procedures:... Wash and scrub for 20 seconds or more... Dry your hands ad arms with a paper towel... Protect clean hands by turning faucets off with a paper towel...."</p> <p>On 2-8-16 at 11:35 A.M., review of the undated policy titled "Food Storage and Handling" provided by the District Manager on 2-8-16 at 9:55 A.M., who stated this was the current policy, indicated "...Always securely cover food items... Write the expiration date of the product...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2016
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS			STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614		
(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	
R 0000 Bldg. 00	3.1-21(i)(2) This visit was for a State Residential Licensure Survey. Residential census: 111 Sample: 7 Sanctuary at St. Paul's was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Sanctuary At St Paul's respectfully requests the Plan of Correction and supporting documentation be considered for desktop review. We declare date of compliance of March 9, 2016.		