

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  02/11/2016
--	---	---	---

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 visit was for the Investigation of Complaints IN00190517, IN00192745 and IN00192819.</p> <p>Complaint IN00190517 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00192745 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00192819 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 7, 8, 9 and 11, 2016.</p> <p>Facility number: 001201 Provider number: 155506 AIM number: 100380860</p> <p>Census bed type: SNF: 38 SNF/NF: 78 Total: 116</p> <p>Census payor type: Medicare: 25 Medicaid: 60</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  02/11/2016
--	---	--	---

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 0323 SS=D Bldg. 00	<p>Other: 31 Total: 116</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 18, 2016.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to follow their fall policy related to the transfer of a resident from the floor to a bed after the resident had sustained a fall to the floor for 1 of 3 residents reviewed for falls.</p> <p>Finding includes:</p> <p>On 2/9/16 the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 7/9/15. The diagnoses included, but were not limited to, polyosteoarthritis unspecified, unspecified dementia without behavioral disturbance and generalized anxiety</p>	F 0323	It is the intent of Sanctuary at Holy Cross to provide an environment as free of hazards as is possible: What corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident B no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified. An audit of the residents which had fallen since date of event revealed no other residents identified. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur. The policy was reviewed and found to	03/02/2016

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  02/11/2016
--	---	---	---

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>disorder.</p> <p>A Minimum Data Set (MDS) assessment, with a reference date of 2/3/15, indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 9 indicating she was moderately cognitively impaired.</p> <p>A nurses note, dated 1/24/16 at 10:34 P.M., indicated "... unwitnessed fall. patient room mate came out to hallway and said she fell, patient was on the floor, vitals taken and within normal range, complaint of pain to right leg and she would not explain what happened, her speech is slurred and that is normal for her after head to toe assessment, doctor was paged 3 times with no call back, family informed and they gave consent to send her to [name of local hospital], administrator notified, and 911 called and she was picked up and meds, code status and face sheet given and I will continue to monitor...."</p> <p>During an interview on 2/11/16 at 4:00 P.M., LPN (Licensed Practical Nurse) #1 indicated the residents room mate alerted staff to the resident's fall on 1/24/16. He further indicated upon entering Resident B's room he found Resident B was lying on the floor at the time, she was unable to tell him what had happened to cause her</p>		<p>be sufficient. Re-education of the staff on the policy. How the corrective action will be monitored to ensure the deficient practice will not recur. Residents that have suffered a fall, their documentation will be reviewed for method in which they are assisted from the floor. The Director of nursing will track and report findings to the Mission Driven Quality Assurance Committee monthly times 6. At that time, the Mission Driven Quality Committee will evaluate the need for further monitoring.</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  02/11/2016
--	---	--	---

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>fall so he began to conduct a head to toe assessment as per facility protocol.</p> <p>During the course of his assessment LPN #1 indicated the resident did not exhibit any indicators of fracture and she was repeatedly attempting to stand unassisted while he was attempting to conduct his assessment. LPN #1 indicated upon completion of his assessment, he placed Resident B in her bed. LPN #1 indicated he did not use a lift to place Resident B in her bed because she was attempting to stand unassisted. LPN #1 indicated he has since been educated to the facilities Safe Transfer procedure.</p> <p>During an interview with the Administrator at 4:50 P.M., the Administrator indicated the facility's policy was to use a lift to transfer a resident from the floor after a fall and that LPN #1 had been provided education as to the facilities post fall transfer procedure but she further indicated she did not believe LPN #1 could have predicted the circumstances of the post fall.</p> <p>On 2/11/16 at 4:45 P.M., a copy of the facilities 12 Principles for Safe Transfers procedure/education was provided by the Administrator. During an interview at that time, the Administrator indicated the staff are trained using the 12 Principles</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  02/11/2016
--	---	---	---

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>for Safe Transfer during orientation and as needed. She indicated staff are expected to utilize the procedure for safe transfer practices; however, the procedure did not indicate a date as to when it was affective or written but did indicate the following: "... A Safe Lifting and Handling Techniques Policy and Procedure has been Developed, the Following are Highlights from the policy...If a resident falls, they will remain on the floor until the nurse assesses the resident and gives the order for you to remove them from the floor using a lifting device to transfer them to the wheelchair or bed, (using the lifting device is <u>MANDATORY</u> to get them up from the floor)...."</p> <p>This Federal deficiency relates to Complaint IN00192745.</p> <p>3.1-45(a)(1)</p>			