DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAUL'S STREET ADDRESS, CITY, STATE, ZIP CODE 3902 \$ IRROWNOOD OR SOUTH BEND, IN 46614 DRAW OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAUL'S SOUTH BEND, IN 46614 DRAW OF PROVIDERS THAN OF CORRECTION FREERING TAG FOR INITIAL COMMENTS FO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
SANCTUARY AT ST PAUL'S SANCTUARY AT ST PAUL'S SANCTUARY AT ST PAUL'S SUMMARY SIZEMENT OF DEFICIENCIES (CACH DESTRICT ACTION SHOULD BE CENTRE THE CORE SHOULD BE CACH DESTRICT ACTION SHOULD BE CACH DESTRUCT ACTION S			155197	B. WING					
PREFIX TAO REGULATORY OR LSC IDINTIFYING INFORMATION) FOOD INITIAL COMMENTS This visit was for the Investigation of Complaint IN00253202, IN00246918 and IN00243388. Complaint IN00253202 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00243388 - Substantiated due to lack of evidence. Survey dates: February 21 and 22, 2018. Facility number: 000104 Provider number: 155197 AIM number: 100266590 Census bed type: SNF: 4 SNF/NF: 59 Residential: 86 Total: 149 Census payor type: Medicare: 9 Medicare: 9 Medicare: 9 Medicare: 9 Medicare: 11 Total: 63 Sanctuary at St. Paul's was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00243388. Quality Review was completed on February 27,	NAME OF PROVIDER OR SUPPLIER				3602 S IRONWOOD DR		1 02/	22/2010	
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ARORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		-				TITI F		(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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155197	B. WING			C 02/22/2018		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE			
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