STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING 00 B. WING	05/23/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 17, 18, 19, 22 and 23, 2023 Facility number: 001201 Provider number: 155506 AIM number: 100380860 Census Bed Type: SNF/NF:36 SNF: 22 Total: 58 Census Payor Type: Medicare: 8 Medicaid: 36 Other: 14 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 6/8/2023.	F 0000	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the 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 the requirements established by state and federal law. Sanctuary at Holy Cross respectfully requests this Plan of Correction and supporting documentation be considered for desktop review/paper compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rayne Wise	Executive Director	06/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Based on observation, record review and interview, the facility failed to assess and monitor a wound for 1 of 1 residents reviewed for skin conditions. (Resident 45) Finding includes: The record for Resident 45, reviewed on 5/22/2023 at 1:54 P.M., indicated the resident's diagnosis included, but were not limited to: hypertensive heart disorder, scoliosis, constipation, pain, hearing loss, cerospinal (sic) shunt, history of falling, unspecified severe protein, adjustment disorder and insomnia. The most recent MDS assessment, completed as a quarterly review on 4/13/2023, indicated the resident was moderately cognitively impaired and required extensive assistance of one person for dressing and personal hygiene needs. During an observation of Resident 46, on 5/18/2023 at 11:36 A.M., a moist, dark pink/red colored centered, pencil eraser sized open sore was observed on the right side of her face. The resident indicated the sore was taking a long time to heal and she tried not to "pick" at it. The resident was observed on 5/19/2023 to have an open, moist, pencil eraser sized wound on the right side of her face. The resident was observed on 5/20/2023 to have an open, moist, pencil eraser sized wound on the right side of her face. During an observation, on 5/22/23 at 9:00 A.M., the open area on Resident 46's face was observed to be dry and covered with a dark reddish/pink scab.	F 0684	1. Resident 45 has had a full skin assessment completed. Any skin impairments identified have been documented, treatment order in place, and provider was notified. 2. All Residents residing in the facility as of 6/15/23 have the potential to be affected. 3. These residents have had a full skin assessment completed for any skin impairments. All skin impairments identified have been documented, treatment order is in place, and provider is aware. All direct care licensed nurses will be re-educated to ensuring they are documenting all skin impairments, notifying the provider, and obtaining treatment orders. 4. Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Nurse Managers, or designee(s), will complete a weekly random audit of three (3) residents to ensure all identified skin impairments have been properly documented and treatment orders in place. A summary report of findings will be provided to the QAPI Program/Committee for review. The QAPI Committee will review findings monthly and determine ongoing need for audits. The facility is confident that these	06/23/2023

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	There was no documentation in the nursing progress notes or recent skin assessments regarding the wound on Resident 46's face. During an interview with the Director of Nursing, on 5/22/23 at 4:00 P.M., he indicated the resident had a spot on her face that she picked at so it was open at times and then closed at times. He indicated the resident had a treatment for dermatitis. The resident's daughter had reported the open area on her face, over the past weekend and nursing staff were going to document on the area and notify the physician "today." Review of the current physician's orders, indicated a treatment, initiated on 11/23/2022 for Triamcinolone acetonide .1% cream to be applied two times a week to Resident 46's face after washing her face with soap and water. The current care plan for risk for skin, indicated the nurse was to be notified of any impaired or red areas for further assessment and the physician was to be notified of impaired skin integrity issues and orders obtained as needed. During an interview with the ADON, on 5/23/23 at 4:11 P.M., she indicated there was no policy regarding skin assessments, just to follow the physician's orders to complete the assessment for every resident twice a week. 3.1-37		corrective measures will be fully implemented by 6/23/23.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed to ensure the physician's order was followed regarding pressure ulcer treatment for 1 of 3 residents reviewed for pressure ulcer care. (Resident 42) Finding includes: 1. Resident 42 was admitted to the facility on 3/3/2023 with diagnoses included, but not limited to: unspecified dementia, status post fracture of the left femur, anemia, diabetes and severe protein calorie malnutrition. A care plan, created on 3/3/2023, for Resident 42 indicated she was at risk for skin breakdown. The goal was to reduce her risks and keep her free from skin breakdown. The interventions included monitoring the skin, using lotions as needed and notifying the MD of any impairments. A change in condition nursing progress note, dated 3/8/2023 at 3:58 P.M., indicated a 3cm (centimeter) by 2.4 cm SDTI (superficial deep tissue injury) area purple and blanchable in color to the left heel. The resident complained of pain. The note indicated skin prep was ordered and	F 0686	1. Resident 42 was assessed. No adverse effects noted. Dressing has been changed as ordered. 2. All residents residing in the facility as of 6/15/23 that have a dressing treatment to a wound have the potential to be affected. Resident's wound dressings were evaluated to ensure it has been changed as ordered. Any dressings found not to be in compliance with physician orders, the wounds will be assessed for any adverse effects, the provider will be notified as needed, and the dressing change to be completed. 3. All direct care licensed nurses will be re-educated on importance of following physician orders and ensuring dressings are changed as ordered.	06/23/2023

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	protective boots applied. On 3/8/2023 a care plan was created for the SDTI of the left inner heel. Interventions included nutritional vitamins and supplements as ordered, treatment as ordered and assessment of area and pain level. On 3/8/2023 a care plan was created for the Stage 2 pressure ulcer to the left buttock. Interventions included nutritional vitamins and supplements as ordered, treatment as ordered and assessment of area and pain level. The current physician's orders related to the treatment of Resident 42's pressure ulcers were as follows: Skin prep to left inner heel, reordered 5/18/2023, Skin prep to right ankle - discontinued on 4/28/2023 and cleanse with normal saline, apply skin prep to dark area of wound and Purocal (collagen dressing) to open area of wound, cover with mepilex daily for a stage 2 pressure ulcer to the coccyx. During an observation with LPN 12, of the dressing change for Resident 42, on 5/22/23 at 11:39 A.M., the old dressing, removed from the resident's buttocks wound, was dated 5/19/2023. A superficial open wound, in the shape of a very small crescent shaped slit was observed just left of the gluteal fold on the lower coccyx. At this time, LPN 12 confirmed the date on the dressing, which she had removed, was 5/19/2023. During an interview with LPN 12, on 5/22/23 at 1:50 P.M., she verified the treatment orders for Resident 42's coccyx wound as a daily dressing change. Review of the facility policy and procoedure,		4. Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Director of Nursing or designee(s), will audit three residents per week to ensure dressings are changed as ordered. A summary report of findings will be provided to the QAPI Program/Committee for review. The QAPI Committee will review findings monthly and determine ongoing need for audits. The facility is confident that these corrective measures will be fully implemented by 6/23/23.	

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	titled, "Pressure injury management, long-term care" provided by the Administrator on 5/22/23 at 2:00 P.M., included instructions on basic wound care and skin assessment recommendations but did not specifically address following the physician's orders to ensure treatments were completed timely. 3.1-40			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and	F 0761	**1.** Resident #202 no longer	06/23/2023

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	interview, the facility failed to ensure narcotics were stored appropriately and failed to ensure liquid medications were dated when opened for 1 of 1 narcotic storage areas and 1 of 12 residents whose medications were observed. (Rehab Narcotic Drawer and Resident 202) Findings include: 1. During a random observation, on 5/22/2023 at 3:14 P.M., the narcotic storage cart was observed to be unlocked. During an interview, on 5/22/2023 at 3:20 P.M., LPN 2 indicated the cart should have been locked. 2. During a medication storage observation, on 5/22/2023 at 3:28 P.M., in Resident 202's medication storage area the following was noted: -An opened and undated bottle of Latanoprost eye drops. -An opened and undated bottle of Dorzolamide 2% eye drops. -An opened and undated bottle of Debrox Ear drops. During an interview, on 5/22/2023 at 3:30 P.M., LPN 2 indicated the opened bottles should have been dated. On 5/23/2023 at 11:46 P.M., the Director of Nursing provided the policy titled,"Storage and Expiration Dating of Medications and Biological's", with a revision date of 7/21/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...3.1 Facility should store Schedule II -V Controlled Substances, in a separate compartment within the locked medication carts and should have a different key or access device... 5. Facility staff		resides in the facility. 2. All residents residing in the facility as of 6/15/23 have the potential to be affected. All medications that have a shortened expiration date once opened have been checked for having the open date on the primary medication container. Any medications found to not be dated as expected will be disposed of and new medication provided to resident. 3. All direct care licensed nurses will be re-educated on proper storage and labeling of medications including controlled medications requiring a double lock. The policy has been reviewed and deemed appropriate. 4. Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Nurse Managers, or designee(s), will complete a weekly random audit of three (3) Resident's medications to ensure medications are appropriately dated. Under the direction of the Quality Assurance Performance Improvement (QAPI) Committee, the Nurse Managers, or designee(s), will complete a weekly random audit of three (3) medication carts to ensure controlled medications are double locked. A summary report of findings will be provided to the QAPI Program/Committee for	

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	should record the date opened on the pharmacy medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened... 5.4 When an ophthalmic solution or suspension has a manufacture's shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container...." 3.1-25(n)		review. The QAPI Committee will review findings monthly and determine ongoing need for audits. The facility is confident that these corrective measures will be fully implemented by 6/23/23.	