

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

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FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155197</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/07/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SANCTUARY AT ST PAUL'S</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3602 S IRONWOOD DR</b><br><b>SOUTH BEND, IN 46614</b>                        |                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                    |
| F 000                                                             | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00289050.</p> <p>Complaint IN00289050 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 7, 2019</p> <p>Facility number: 000104<br/>Provider number: 155197<br/>AIM number: 100266590</p> <p>Census bed type:<br/>SNF/NF: 9<br/>Total: 9</p> <p>Census payor type:<br/>Medicaid: 7<br/>Other: 2<br/>Total: 9</p> <p>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 Complaint IN00289050.</p> <p>Quality Review was completed on March 8, 2019.</p> | F 000                                                                      |                                                                                                                          |                            |                                                                    |

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.