STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SANCTUARY AT ST PAUL'S	3602 SOUTH IRONWOOD DRIVE SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00402109. Complaint IN00402109 - No deficiencies related to the allegations are cited. Survey dates: June 21 and 22, 2023 Facility number: 014602 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 6/26/2023.	R 0000		
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review the facility failed to obtain an admission	R 0216	1. What corrective action(s) will be accomplished for those residents	07/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kris Borkowski	LPN/DON	07/07/2023

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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	weight for 1 of 7 residents reviewed for weights. (Resident B) Finding includes: A record review was completed on 6/21/2023 at 11:00 A.M. Diagnoses included, but not limited to: chronic pain, hypertension, polyneuropathy and osteoarthritis. The record lacked a documented admission weight. During an interview on 6/21/2023 at 2:40 P.M., the Director of Nursing indicated Resident B should have had an admission weight. On 6/22/2023 at 10:47 A.M., the Director of Nursing provided a policy titled, "Weight and Height Program", dated March 2023, and indicated the policy was the one currently used by the facility. The policy indicated "...Process: 1. A resident's weight and height will be obtained no later than 24 hours after admission, with weights monthly thereafter, unless otherwise directed by the IDT and/or physician...."		found to have been affected by the deficient practice; Resident B weights obtained have been reviewed and have remained steady. No adverse effects noted to as a result of not obtaining a weight on admission. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who to the facility prior to December of 2021 have the potential to be affected. These charts have been audited to ensure an admission weight was obtained. Any resident found not to have an admission weight, monthly weights will be reviewed to ensure weights are maintained and residents have had no adverse effects. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The policy “weight and height program” has been reviewed and updated. A new admission audit process has been implemented which includes ensuring the weight has	

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			been obtained. All direct care staff have been re-educated on requirement to obtain and height upon admission. 4. 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 All new admissions will be audited to ensure weight is obtained upon admission per policy. A summary report of will be provided to the QAPI Program/Committee for review. The QAPI Committee will review findings monthly and determine ongoing need for audits. 5. By what date be completed. The facility is confident that these corrective measures will be fully implemented by July 14, 2023 The Administrator is responsible for sustained compliance.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure 2 of 4 staff (Employee 4 and 5) observed preparing and serving food followed safe food handling standards. This deficient practice had the potential to affect 75 of 75 resident who consume food from the kitchen. Finding includes: During the meal preparation and serving on the noon meal, on 6/21/2023 between 11:30 A.M. - 12:07 P.M., the following was observed: - Cook 4 was wearing gloves while preparing bread for cheesy garlic toast. He then ripped open a plastic bread bag and placed a stack of bread onto a sheet pan with tongs. He touched the top of the bread to cut the bread into triangles and then used his hands to put the bread back out onto the cookie sheet. - Cook 5 was preparing to put food onto plates for the noon meal. He washed his hands and donned gloves, then with his gloved hands, touched steam table lids, a black pallet plate warmer, a kitchen drawer, handles of tongs, spoodles and ladles, and a plastic bag containing hot dog style buns. Cook 5 reached in the plastic bag with the hot dog buns and grabbed a bun, he then placed the bun on his opened gloved hand	R 0273	ol class="NumberListStyle1 SCXW211933893 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents consuming food from the kitchen have the potential to be affected. Residents' infection control log indicates no residents have had any s/s related to food contamination illness. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; p paraid="933147835"	07/14/2023

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	and put the toppings onto the bun. During an interview with the Food Service Supervisor from the facility's sister facility, on 6/21/2023 at 12:10 P.M., he indicated he would complete an inservice immediately regarding food handling and glove use. Review of the current facility policy and procedure, titled, "Safety and Sanitation," provided by the Food Service Supervisor on 6/21/2023 at 1:00 P.M., included the following: "...Single use Food Handling Gloves shall be used for only one task, and then discarded...single use gloves should always be changed when moving from one task to another...Remove gloves when: Dirty, stained of (sic) showing signs of wear, moving to another new task or work area...touching soiled food contact areas...moving from food prep to food service, after handling non-food items...."		paraeid="{426f7e66-62bf-4ca4-9844-e80bece647e5}{29}" > No other residents have the potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; p paraid="564740260" paraeid="{426f7e66-62bf-4ca4-9844-e80bece647e5}{58}" >All dietary staff will be in- on Glove Use per the Safety and Sanitation policy. 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 Dining services director or will audit glove use practices 3x a week to ensure dietary staff are	

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			following glove use policy. A summary report of will be provided to the QAPI Program/Committee for review. The QAPI Committee will review findings monthly and determine ongoing need for audits. ol class="NumberListStyle1 SCXW211933893 BCX8" role="list" start="5" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" By what date be completed. The facility is confident that these corrective measures will be fully implemented by July 14, 2023 The Administrator is responsible for sustained compliance.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.			

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	(2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on observation, interview, and record review the facility failed to complete an accurate Resident Emergency File for 5 of 7 records reviewed. (Residents B, C, D, E & H) Findings include: 1. A record review was completed on 6/21/2023 at 11:00 A.M., for Resident B. Diagnoses included, but not limited to: chronic pain, hypertension, polyneuropathy and osteoarthritis. A copy of the emergency file was provided on 6/21/2023 at 2:30 P.M. by the Director of Nursing (DON). The Emergency File information for Resident B had a missing photograph and a copy of advanced directive. 2. A record review was completed on 6/21/2023 at 6/21/2023 at 11:00 A.M., for Resident C. Diagnoses included, but not limited to: heart failure and atrial fibrillation. A copy of the emergency file was provided on 6/21/2023 at 2:30 P.M. by the DON. The Emergency File information for Resident C had a missing photograph and a copy of advanced	R 0356	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Emergency Information File was updated and in compliance for residents B, C, D, E & H with a photo and advance directive. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents residing in the assisted living have the potential to be affected. An immediate audit was completed for all residents. The Emergency Information File was updated as needed and in compliance for all residents with a photo and advance directive. 3. What measures will be put into	06/23/2023

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	directive. 3. A record review was completed on 6/21/2023 at 2:00 P.M., for Resident D. Diagnoses included, but not limited to: chronic obstructive pulmonary disease, neuropathy, cellulitis, asthma, and atrial fibrillation. A copy of the emergency file was provided on 6/21/2023 at 2:30 P.M. by the DON. The Emergency File information for Resident D had a missing photograph and a copy of advanced directive. 4. A record review was completed on 6/21/2023 at 2:00 P.M., for Resident E. Diagnoses included, but were not limited to: diabetes, dementia and right knee and hip joint replacement. A copy of the emergency file was provided on 6/21/2023 at 2:30 P.M. by the DON. The Emergency File information for Resident E had a missing photograph and a copy of advanced directive. 5. A record review was completed on 6/21/2023 at 2:15 P.M., for Resident H. Diagnoses included, but were not limited to: displaced intertrochanter fracture of the left femur. A copy of the emergency file was provided on 6/21/2023 at 2:30 P.M. by the DON. The Emergency File information for Resident H had a missing photograph and a copy of advanced directive. During an interview on 6/22/2023 at 10:47 A.M., the DON indicated the advance directive and photographs should have been in the Emergency File Information book.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Admission chart audit tool has been updated to include the emergency file information. The Assisted Living Manager (DON) and Unit Coordinator have been re-educated on the importance of ensuring a photo is taken for their file as well as ensuring the advance directive is placed in the file. Files to be audited on an ongoing basis every 6 months in alignment with residents 6-month assessments to ensure file is complete and . 4. 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 All new admissions will be audited to ensure the emergency file is complete with photos and advance directives. A summary report of will be provided to the QAPI Program/Committee for review. The QAPI Committee will review findings monthly and determine	

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	On 6/22/2023 at 10:47 A.M., the DON provided a policy titled, "Emergency Information File", dated 3/20/20, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The current information file shall be immediately accessible for each resident, in case of emergency, that contains the following: a. The resident's name, sex, room or apartment number, phone number, age, or date of birth. b. The resident's hospital preference. c. The name and phone number of any legally authorized representative. d. The name and telephone number of the resident's physician of record. e. The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. f. Information on any known allergies. g. A photograph (for identification of the resident). h. A copy of the advance directives, if available...."		ongoing need for audits. 5.By what date be completed. The facility is confident that these corrective measures will be fully implemented by June 23, 2023 The Administrator is responsible for sustained compliance.	