| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155214 | A. BUILDING 00<br>B. WING | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SAINT ANTHONY | 203 FRANCISCAN DR<br>CROWN POINT, IN 46307 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00348505.<br><br>Complaint IN00348505 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: March 23, 2021<br><br>Facility number: 000120<br>Provider number: 155214<br>AIM number: 100274780<br><br>Census Bed Type:<br>SNF: 14<br>SNF/NF: 132<br>NCC: 2<br>Total: 148<br><br>Census Payor Type:<br>Medicare: 24<br>Medicaid: 86<br>Other: 38<br>Total: 148<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review was completeed on March 25, 2021. | F 0000 | | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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| | necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on record review and interview, the facility failed to ensure necessary care and services were provided to residents who required extensive and dependent care for activities of daily living (ADL's), related to showers for 2 of 3 residents reviewed for ADL's. (Residents C and D)<br><br>Findings include:<br><br>1) During an interview on 3/23/21 at 9:15 a.m., Resident C indicated she had not had a shower since she was admitted to the facility. She had received some bed baths, though her preference was showers. She would really like to have a shower.<br><br>Resident C's record was reviewed on 3/23/21 at 10:09 a.m. The diagnoses included, but were not limited to a fracture of the left femur.<br><br>An Admission Minimum Data Set assessment (MDS), dated 1/13/21, indicated an intact cognitive status and no behaviors were present. It was very important to her to choose between a tub bath, shower, bed bath or sponge bath, she required extensive assistance of two for bed mobility, extensive assistance of one for hygiene, and limited assistance of one for bathing.<br><br>A Care Plan, dated 1/7/21, indicated assistance was needed for ADL's. The interventions included, limited assistance of one staff for bathing/showering.<br><br>The shower schedule, identified as current by the Unit Manager, reviewed on 3/23/21 at 10:57 a.m., indicated the showers were scheduled for | F 0677 | F677<br>1:1 Regarding residents C & D staff completed ADL care without adverse reactions noted.<br>1:2: The Director of Activities/designee reviewed the resident choice questionnaire with the resident/ responsible party house wide to ensure accuracy. The Director of Activities/designee provided the questionnaire to the Nurse Managers/designee to update the care cards as well as the resident's bathing schedules with preferences.<br>The Nurse Managers/designee assessed the residents to ensure ADL's were completed evidenced by completed personal care tasks which includes bathing/showers, nail care, grooming, oral hygiene, dressing, toileting, repositioning, eating, & drinking. Any deficiencies were corrected at that time.<br>1:3 The Infection Preventionist Staff Development/designee re-in-serviced the nursing staff on the importance of completing daily personal care tasks per the plan of care as well as how to document completion in the medical record & on the shower sheets. The Nurse Manager/designee will observe/speak to (5) five residents per unit weekly on the day & evening shifts to ensure showers | 04/15/2021 |

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| | Wednesday and Saturday evenings.<br><br>During an interview on 3/23/21 at 11:06 a.m., CNA 2 indicated all showers and bed baths were documented on the shower/skin sheet. There was a three ring binder the shower/skin sheets were kept in at the desk.<br><br>During an interview on 3/23/21 at 11:07 a.m., RN 1 indicated the CNA's documented on the shower/skin sheet when the bathing was completed. They documented what type of bathing was completed. The Kardex (CNA care instructions) indicated Resident C preferred showers.<br><br>Review of the three ring binder indicated Resident C received a bed bath on 2/6/21 and 3/6/21. There were no further shower/skin sheets in the binder.<br><br>The Staff Educational Nurse, provided shower/skin sheets on 3/23/21 at 12:59 p.m., which indicated a bed bath was given on February 3, 10, 20, and 24, 2021 and March 10,13, and 20, 2021.<br><br>There were no shower skin sheets that indicated the resident was bathed on February 13, 17, 27, 2021 and March 3 and 17, 2021.<br><br>2) Resident D's record was reviewed on 3/23/21 at 11:16 a.m. The diagnoses included, but were not limited to, left femur fracture and dementia.<br><br>An Admission MDS assessment, dated 1/8/21, indicated a moderately impaired cognitive status. It was somewhat important to choose between a tub bath, shower, bed bath or sponge bath, required extensive assistance of two for bed mobility and had not received bathing in the past seven days. | | were given per preference & per schedule. The Nurse Manager/designee will also ensure documentation was completed on the shower sheet & will review the shower sheets from the previous day in the morning clinical meeting to ensure completion on the next business day for six (6) months.<br>1:4: The DON/Designee will report audit findings to the QAPI committee meeting monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.<br>1:5 Systemic changes will be complete by 4-15-21 | |

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| | A Care Plan, dated 1/11/21, indicated assistance with ADL's was required. The interventions indicated total assistance of one staff was needed for bathing.<br><br>The Shower Schedule indicated the showers were scheduled for Tuesday and Friday during the day shift.<br><br>The Shower/Skin Sheet binder indicated on on 2/2/19 a shower was given, on 2/5/21 a bed bath was given, and on 2/19/21 a shower was given.<br><br>The Staff Educational Nurse, provided shower/skin sheets on 3/23/21 at 1 p.m., which indicated a bed bath was given on 2/9/21 and 2/23/21. A bed bath was given on 3/2/21, 3/9/21, and 3/19/21.<br><br>There were no Shower/Skin Sheets that indicated the resident was bathed on February 12, 16, and 26, 2021 and March 5 and 16, 2021.<br><br>During an interview on 3/23/21 at 11:49 a.m., the Unit manager indicated the resident's preference for bathing was a shower, per the kardex.<br><br>During an interview on 3/23/21 at 11:54 a.m., CNA 2 indicated she had given the resident a bed bath this morning.<br><br>This Federal tag relates to Complaint IN00348505.<br><br>3.1-38(b)(2) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents. | | | |

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| | The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review, and interview, the facility failed to ensure a fall risk intervention was in place for a resident who had a history of falls for 1 of 1 resident reviewed for fall interventions. (Resident E)<br><br>Finding includes:<br><br>Resident E was observed on 3/23/21 at 9:19 a.m., 10:51 a.m., and 12 p.m., sitting in the wheelchair in her room. The call light was located behind the wheelchair clipped on the cord, next to the wall unit.<br><br>During an interview on 3/23/21 at 12 p.m., the resident indicated she was not sure how she could get help if she needed help. The Unit Manager indicated the call light was not accessible to the resident.<br><br>Resident E's record was reviewed on 3/23/21 at 12:23 p.m. The diagnoses included, but were not limited to, fracture of the right femur, dementia, and repeated falls.<br><br>An Admission Minimum Data Set assessment, dated 2/2/21, indicated a severely impaired cognition status, required extensive assistance of two staff for transfers, had fallen in the last month prior to admission into the facility, had fallen within two to six months prior to admission into the facility, and had a fracture related to a fall. | F 0689 | F689<br>1:1 Regarding resident E the licensed nurse placed the call light within this resident's reach. No adverse effects noted.<br>1:2: The Administrator/ED/designee completed a whole house call light audit. All residents call lights were within reach.<br>1:3: The Infection Control Preventionist Staff Development/designee re-in-serviced the staff on proper resident call light placement. The Nurse Managers/designee will randomly audit five (5) resident call lights per unit per shift five (5) times a week to ensure proper placement for six (6) months.<br>1:4: The DON/Designee will report audit findings to the QAPI committee meeting monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.<br>1:5 Systemic changes will be complete by 4-15-21 | 04/15/2021 |

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A Care Plan, dated 2/3/21, indicated she was a risk for falls and had a history of falls. The interventions included, to keep the call light within reach of the resident.

The Fall Risk assessments, dated 1/27/21, 2/26/21, and 3/11/21, indicated she was a high risk for falls.

The Nurses' Progress Notes, indicated:
On 2/26/21 at 1:53 p.m., the resident was found on the floor due to sliding from the wheelchair.

On 3/1/21 at 3:13 p.m., the Interdisciplinary Team (IDT) met and added dysom to the wheelchair and indicated to continue all care planned fall interventions.

On 3/11/21 at 6:58 p.m., the resident was found on the floor. The resident indicated the floor was slippery to walk on.

On 3/12/21 at 10:51 a.m., the IDT met and indicated to continue all care planned fall interventions.

A facility policy, dated 10/2019, titled, "Fall Management", received from the Administrator as current, indicated a Care Plan would be developed at the time admission and all of the resident's fall risk factors would be addressed. The IDT would meet and the fall risk would be discussed and appropriate fall interventions would be placed on the Care Plan. All falls were to be reviewed by the IDT and the Care Plan would be reviewed and updated as necessary.

3.1-45(a)(2)