STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	06/18/2021

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00353349, IN00353768, and IN00354645. Complaint IN00353349 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00353768 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00354645 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 14, 15, 16, 17, and 18, 2021 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 136 SNF: 15 NCC: 2 Total: 153 Census Payor Type: Medicare: 12 Medicaid: 98 Other: 43 Total: 153 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/24/21.	F 0000	The Facility respectfully requests a desk review.	

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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F 0553 SS=D Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.			
	Based on record review and interview, the facility failed to facilitate resident and responsible party care planning involvement related to lack of invitations to care plan meetings for 1 of 30	F 0553	The Facility respectfully requests a desk review. F553 1:1 Regarding resident #120 no	07/16/2021

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	residents reviewed for care plans. (Resident 120) Finding includes: Resident 120's record was reviewed on 6/16/21 at 9:03 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, and seizures. The resident was admitted to the facility on 3/25/21. An Admission Minimum Data Set (MDS) assessment was dated 3/25/21. A Significant Change MDS assessment was dated 5/7/21. The resident was cognitively impaired. The record lacked any indication the resident's responsible party was invited to any care plan meetings. Interview with Social Services 2 on 6/18/21 at 9:42 a.m., indicated Resident 120 was not on her list of care plan meetings from the MDS staff. There should have been a care plan meeting every three months or if the resident had a change in status. Interview with MDS Nurse 2 and the MDS Director on 6/18/21 at 9:54 a.m., indicated Resident 120 was not on their list to have a care plan meeting, it was missed. MDS would put the schedule in a binder when a resident was admitted, readmitted, due for an annual, every three months, if the family or staff requests a meeting, or a change in status. 3.1-3 (d)		adverse reactions were noted. The responsible party was contacted & a care plan meeting was scheduled per the responsible party's convenience. 1:2: The Director of MDS/designee audited MDS/care planning schedules for the past 90 days to ensure all residents/responsible parties were notified & invited to the resident's care plan meeting. Any deficiencies were corrected at that time. 1:3 The Director of MDS/designee re-in-serviced the IDT team on the importance of inviting residents & responsible parties to care plan meetings per the federal guidelines. The Director of MDS/designee will audit the MDS schedule weekly to ensure residents & responsible parties were notified & invited to the resident's care plan meeting for six (6) months. 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.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive			

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	services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a resident's needs were met related to a call light out of reach for 1 of 30 residents observed for accommodation of needs. (Resident 45) Finding includes: During an observation/ interview with Resident 45 on 6/15/21 at 9:35 a.m., he indicated he had to verbally call out for help. The call light was observed to be at the foot of the bed, not within reach of the resident's. During the Environmental Tour with the Maintenance Supervisor and the Administrator on 6/17/21 at 10:45 a.m., Resident 45's call light was observed on a hook on the wall at the foot of the bed, not within reach of the resident. The Maintenance Supervisor clipped the call light to the resident's sheet on his upper right side. The resident was able to activate the call light. Interview with the Administrator on 6/17/21 at 10:45 a.m., indicated the CNAs and nurses should be making sure his call light is within reach. The "Magic Maker Ambassadors" are staff that have been assigned 6 rooms and complete rounds to make sure everything is in its proper place. Interview with CNA 9 on 6/17/21 at 2:02 p.m., indicated the resident could use his call light. Resident 45's record was reviewed on 6/17/21 at 1:55 p.m. Diagnoses included, but were not	F 0558	The Facility respectfully requests a desk review. F558 1:1 Regarding resident #45 the Director of Maintenance placed the call light within this resident's reach during environmental rounds. No adverse effects noted. 1:2: The Administrator/ED/designee completed a whole house call light audit. All residents call lights were within reach. 1:3: The Director of 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. The Facility also has the Magic Moments program. This program assigns Managers to a group of residents to follow on five (5) times a week to ensure all activities of daily living needs are met, their concerns are heard, & that their lives are being celebrated. 1:4: The DON/Designee will report audit findings to the QAPI committee meeting monthly for (6) months. The QAPI committee will	07/16/2021

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	limited to, Multiple sclerosis. The Minimum Data Set assessment, dated 3/30/21, indicated the resident was cognitively intact and did not have an upper extremity impairment. 3.1-3(v)(1)		monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-			

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	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to ensure the resident's representative was promptly notified of a change in condition for 1 of 1 residents reviewed for a change of condition. (Resident 120) Finding includes: Interview with Resident 120's representative, on 6/14/21 at 2:50 p.m., indicated she was unsure why the resident was sent to the hospital recently. Resident 120's record was reviewed on 6/16/21 at 9:03 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, and seizures. The Admission Minimum Data Set assessment, dated 4/6/21, indicated the resident was cognitively impaired.	F 0580	The Facility respectfully requests a desk review. F580 1:1 Regarding resident #120 the resident was sent to the hospital for an evaluation related to a condition change per physician's order. 1:2 The Nurse Manager/designee reviewed residents with a condition change which also included residents who have been transferred to the hospital in the last 90 days to ensure the Physician/POA/RP were notified timely. Any deficiencies were corrected at that time. 1:3 The Director of Staff Development/designee re-in-serviced the licensed staff on	07/16/2021

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	A Nurse Progress Note, dated 4/21/21 at 11:47 p.m., indicated the resident was uncooperative and resistant to care. The Nurse Practitioner was notified and instructed the Nurse to send the resident's to the Emergency Room for a Psychological evaluation. 911 was called and the resident's was sent via ambulance to the Emergency Room. A Nurse Progress Note, dated 4/22/21 at 7:11 a.m., indicated the resident returned from the hospital. The record lacked any indication that the resident's responsible party was notified of the resident's change in health status. Interview with Social Services 2 on 6/17/21 at 1:12 p.m., indicated if the resident was sent out for an emergency, it was up to the nurse to notified the resident's representative. Interview with the 3A Unit Manager on 6/17/21 at 3:29 p.m., indicated the Nurse should have notified the resident's representative when the resident was sent to the Emergency Room. A policy titled, "Change in Condition," was provided by the the Director of Nursing on 6/17/21 at 4:14 p.m. This current policy indicated, "Procedure:...c. The licensed nurse will notify the family/responsible party of resident change of condition and document notification...." 3.1-5(a)(2)		the Change in Condition policy which encompasses timely notification of Physician & POA/RP. The IDT will audit the medical record/24-hour report of residents who have had a condition change which includes hospitalizations to ensure timely notification of Physician & POA/RP at the next business day's morning meeting. The IDT will also hold an afternoon clinical meeting to ensure identified notifications have been completed from the morning clinical meeting if applicable. 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.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer.			

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	Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility			

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	for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior			

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	to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the resident's responsible party was provided a written notice for the reason of transfer when sent to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 120) Finding includes: Interview with Resident 120's representative, on 6/14/21 at 2:50 p.m., indicated she was unsure why the resident was sent to the hospital recently. Resident 120's record was reviewed on 6/16/21 at 9:03 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, and seizures. The Admission Minimum Data Set assessment, dated 4/6/21, indicated the resident was cognitively impaired. A Nurse Progress Note, dated 4/21/21 at 11:47	F 0623	The Facility respectfully requests a desk review. F623 1:1 Resident #120 was sent to the hospital for an evaluation & returned to the facility per physician’s orders. 1:2 The Director of Social Service/designee audited resident’s charts who were transferred to the hospital within the past 90 days to ensure the resident or the resident’s responsible party was provided a written notice for the reason of transfer to the hospital. Any deficiencies were corrected at that time. 1;3 The Director of Staff Development/designee will re-educate staff on ensuring the resident or the responsible party is provided a written notice for the	07/16/2021

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	p.m., indicated the resident was uncooperative and resistant to care. The Nurse Practitioner was notified and instructed the Nurse to send the resident to the Emergency Room for a Psychological evaluation. 911 was called and the resident went via the ambulance to the Emergency Room. A Nurse Progress Note, dated 4/22/21 at 7:11 a.m., indicated the resident returned from the hospital. The record lacked any indication that the resident's responsible party was provided a written notice of the reason of the transfer when the resident was sent out to the hospital. Interview with Social Services 2 on 6/17/21 at 1:12 p.m., indicated she was unaware that Resident 120 was sent to the hospital. The transfer form and notice of transfer should have been mailed to the resident's responsible party. Interview with the 3A Unit Manager on 6/17/21 at 3:29 p.m., indicated the transfer paperwork, which included the transfer form and notice of transfer, should have been copied before the resident was sent to the hospital. Social Services would then mail the paperwork to the resident's responsible party in a timely manner. A policy titled, "Transfer or Discharge Notice," was provided by the Director of Nursing on 6/17/21 at 4:14 p.m. This current policy indicated, "...Policy Interpretation and Implementation...3. The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge; b. the effective date of the transfer or discharge:, c The location to which the resident's is being transferred or discharged; d. A statement of the		reason of transfer when sent to the hospital. The Director of Social Service/designee will audit the required paperwork that is to be sent with a resident/responsible party which includes a written notice for the reason of transfer when sent to the hospital weekly for six (6) months. 1:4 The DON/designee will report audit findings to the QAPI committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	resident's rights to appeal the transfer...e. The facility bed-hold policy...." 3.1-12 (a)(9)(A) 3.1-12 (a)(9)(B) 3.1-12 (a)(9)(C) 3.1-12 (a)(9)(D) 3.1-12 (a)(9)(E) 3.1-12 (a)(9)(F) 3.1-12 (a)(9)(G)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the			

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(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
	resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure each resident or the resident's responsible party was provided a written notice of the bed hold policy and the appeal of rights information when a resident was transferred to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 120) Finding includes: Interview with Resident 120's representative, on 6/14/21 at 2:50 p.m., indicated she was unsure why the resident was sent to the hospital recently. Resident 120's record was reviewed on 6/16/21 at 9:03 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, and seizures. The Admission Minimum Data Set assessment, dated 4/6/21, indicated the resident was cognitively impaired. A Nurse's Progress Note, dated 4/21/21 at 11:47 p.m., the resident was uncooperative and resistant to care. The Nurse Practitioner was notified and instructed the Nurse to send the resident's to the Emergency Room for a Psychological evaluation. 911 was called and the resident went via the ambulance to the Emergency Room. A Nurse's Progress Note, dated 4/22/21 at 7:11 a.m., indicated the resident returned from the hospital. The record lacked any indication the resident's responsible party was provided a written notice of	F 0625	The Facility respectfully requests a desk review. F625 1:1 Resident #120 was sent to the ER for an evaluation & returned to the facility per physician's orders. 1:2 The Director of Social Service/designee audited resident's charts who were transferred to the hospital within the past 90 days to ensure the resident or the resident's responsible party was provided a written notice of the bed hold policy as well as the appeal of rights information. Any deficiencies were corrected at that time. 1;3 The Director of Staff Development/designee will re-educate staff on the transfer or discharge notice policy to ensure all documentation is sent to the appropriate parties when a resident is transferred to the hospital. The Director of Social Service/designee will audit the required paperwork that is to be sent with a resident to the hospital as well as the required paperwork that the responsible party is to receive on all residents who are sent to the hospital weekly for six (6) months. 1:4 The DON/designee will report audit findings to the QAPI	07/16/2021

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	the bed hold policy and the appeal of rights information upon transfer to the hospital. Interview with Social Services 2, on 6/17/21 at 1:12 p.m., indicated she was unaware that Resident 120 was sent to the hospital. The transfer form and notice of transfer should have been mailed to the resident's responsible party. Interview with the 3A Unit Manager on 6/17/21 at 3:29 p.m., indicated the transfer paperwork should have been copied before the resident was sent to the hospital. Social Services would then mail the paperwork to the resident's responsible party in a timely manner. A policy titled, "Transfer or Discharge Notice," was provided by the Director of Nursing on 6/17/21 at 4:14 p.m. This current policy indicated, "...Policy Interpretation and Implementation...3. The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge;... d. A statement of the resident's rights to appeal the transfer...e. The facility bed-hold policy...." 3.1-25 (a)(25)		committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received the assistance they needed with ADLs (activities of daily living) related to	F 0677	The Facility respectfully requests a desk review. F677 1:1 Regarding residents R, F, N, &	07/16/2021

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	facial hair grooming and fingernail care for 4 of 11 residents reviewed for ADL's. (Residents R, F, N and O) Findings include: 1. On 6/14/21 at 9:58 a.m., Resident R was observed in her bed. She had long, approximately one inch, hairs growing on her chin. On 6/17/21 at 9:15 a.m., she was observed in bed with long hairs still on her chin. The Resident's record was reviewed on 6/14/21 at 10:06 a.m. Diagnoses included, but were not limited to, Lewy Body dementia and delusional disorder. The Quarterly Minimum Data Set assessment, dated 5/19/21, indicated the resident had severe cognitive impairment and required assistance with ADLs. The ADL care plan, dated 9/2/20, indicated the resident needed extensive assistance with personal hygiene. Interview with CNA 5 on 6/17/21 at 11:35 a.m., indicated they were aware the resident had facial hair and they would get to it. 2. On 6/15/21 at 11:05 a.m., Resident F was observed lying in bed. The resident's fingernails were observed with dark debris underneath them. On 6/15/21 at 3:40 p.m., Resident F was observed lying in bed. The resident's fingernails were observed with dark debris underneath them. On 6/16/21 at 1:04 p.m., Resident F was observed sitting in a wheelchair in her room. The resident		O staff completed ADL care without adverse reactions noted. 1:2: 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, facial grooming, oral hygiene, dressing, toileting, repositioning, eating, & drinking. Any deficiencies were corrected at that time. The Facility also has the Magic Moments program. This program assigns Managers to a group of residents to follow on five (5) times a week to ensure all activities of daily living needs are met, their concerns are heard, & that their lives are being celebrated. 1:3 The Director of 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. The Nurse Manager/designee will observe (5) five residents per unit per week to ensure daily personal care tasks have been performed for (6) six months. The Nurse Manager/designee will also ensure personal care tasks have been documented on these residents in the medical record as completed for (6) six months. The Nurse Managers/designee will review shower sheets from the previous	

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	indicated she had just returned from a dialysis appointment. The resident's fingernails were observed with dark debris underneath them. Record review for Resident F was completed on 6/16/21 at 1:10 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, diabetes mellitus, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 3/22/21, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist with bed mobility, transfers, toilet use, and personal hygiene. A Care Plan indicated the resident required assistance with activities of daily living due to disease process and activity intolerance. Interventions included to complete nail care on bath day and as necessary. A Shower Sheet, dated 6/15/21, indicated the resident received a bed bath. There was no documentation on the sheet that indicated nail care was completed. Interview with CNA 1 and LPN 1 on 6/16/21 at 1:09 p.m., indicated the resident received bed baths on Tuesday and Friday evenings. The CNA indicated she completed incontinence care with the resident but did not normally clean her nails. The LPN indicated the staff should have cleaned the resident's nails the evening before when she received her bed bath.3. On 6/14/21 at 11:30 a.m., Resident N was observed lying in bed with long fingernails that had a brown substance under the nails. An interview with the resident at that time, indicated they trimmed his fingernails about 2 weeks ago, but they do not clean under the nails.		day in the morning clinical meeting to ensure completion on the next business day for six (6) months. 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.	

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On 6/16/21 at 8:37 a.m., Resident N was observed lying in bed, with long fingernails that had a brown substance under the nails. An interview with the resident at that time indicated he had a shower yesterday.

Resident N's record was reviewed on 6/16/21 at 8:38 a.m. Diagnoses were included, but not limited to, stroke and diabetes mellitus.

The "3A Shower Lists" indicated the resident was to have showers on Tuesdays and Fridays.

The Shower Sheet, dated 6/15/21, indicated the resident had a shower completed. The Shower Sheet lacked documentation that the fingernails were groomed or the resident had refused.

The following Shower Sheets also lacked documentation that the fingernails were groomed or the resident had refused:
- 6/11/21 complete bed bath
- 6/8/21 shower
- 6/4/21 shower
- 6/1/21 shower

A Significant Change Minimum Data Set assessment, dated 3/21/21, indicated the resident was an extensive one person assist with personal hygiene and was totally dependent one person assist for bathing.

The record lacked any care plan for refusing care.

Interview with CNA 7 and LPN 5 on 6/16/21 at 9:36 a.m., indicated nail care is performed if the resident needed it and if the resident refused, that also would have been marked on the Shower Sheets.

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Interview with CNA 7 on 6/16/21 at 10:51 a.m.., indicated she had cleaned his fingernails and trimmed them, and the fingernails did have a brown substance underneath.

4. On 6/15/21 at 9:52 a.m., Resident O was observed to be lying in bed, with long fingernails that had a brown substance under the nails. An interview with the resident at that time, indicated she needed her fingernails cut. She asked the staff to cut them and they had not yet.

On 6/16/21 at 8:52 a.m., Resident O was observed to be lying in bed, with long fingernails that had a brown substance under the nails

Resident O's record was reviewed on 6/16/21 at 8:41 a.m. Diagnoses were included, but not limited to, stroke and heart failure.

The "3C Shower Lists" indicated the resident was to have showers on Wednesdays and Saturday evenings.

The Shower Sheets for 6/2, 6/5, and 6/12/21 indicated the resident's received a complete bed bath. The documentation lacked any indication if the fingernails were groomed or the resident had refused.

A Significant Change Minimum Data Set assessment, dated 5/5/21, indicated the resident was an extensive two person assist with personal hygiene and was totally dependent one person assist for bathing.

A Care Plan, dated 2/3/21, indicated the resident needed assistance with activities of daily living. An intervention for bathing/showering included for nail care to be performed on bath day and as

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	necessary. Interview with CNA 7 on 06/16/21 9:36 a.m., indicated usually the evening CNA would perform bathing and that was usually when nail care was performed. Interview with the 3C Unit Manger on 6/16/21 at 3:08 p.m., indicated the resident's fingernails needed to be cleaned and could be trimmed if that was what the resident's requested. This Federal tag relates to Complaint IN00353349. 3.1-38 (a)(3)(D)(E)			
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. Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary treatment and services related to the monitoring and assessment of skin discolorations and treatment of an arterial wound for 3 of 6 residents reviewed for non-pressure related skin conditions. (Residents 28, 127, and 37) Finding includes: 1. On 6/15/21 at 9:59 a.m., Resident 28 was observed lying in bed. Multiple purple	F 0684	The Facility respectfully requests a desk review. F684 1.1: The Unit Manager completed a head-to-toe assessment of resident #28 & #127. An incident report was completed on the identified areas. Non-pressure skin evaluations and care plans were also completed. The Physician and the RP were both notified of the findings. No	07/16/2021

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	discolorations of varying sizes were noted to both arms. A large purple discoloration was noted to her right thumb/ wrist/ top of the hand. On 6/16/21 at 4:30 p.m., Resident 28 was observed seated in a broda chair in her room watching television. She had tubigrips (elastic bandage) in place to both arms. The large purple discoloration to her right thumb/ wrist/ top of the hand was visible. On 6/17/21 at 10:44 a.m., the resident was seated in her broda chair in her room. Multiple purple discolorations of varying sizes remained to both arms. The large purple discoloration to her right thumb/ wrist/ top of the hand remained. Interview on 6/17/21 at 10:57 a.m. with the ADON, indicated she was the resident's nurse today. She would make sure to assess and document the skin discolorations immediately. Record review for Resident 28 was completed on 6/17/21 at 1:09 p.m. Diagnoses included, but were not limited to, heart failure, atrial fibrillation, and anemia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/21, indicated the resident was cognitively impaired. The resident required a 2+ person assist for dressing and toilet use, and 1 person assist with personal hygiene. The resident had received anticoagulant (blood thinning) medication. A Care Plan indicated the resident received anticoagulant therapy. An intervention included to inspect skin during care for bruising or increased bruising and to observe for signs of abnormal bleeding such as increased frequency of		adverse reactions noted. The Unit Manager completed a head-to-toe assessment of resident #37. A non-pressure skin evaluation was completed for the right shin. Skin sheets and care plans were also completed. The Physician was already aware of the identified area however, the RP was made aware of the findings. No adverse reactions noted. 2.1: Unit Managers / designees completed head-to-toe assessments on all residents to ensure identification and notification of discolorations/skin tears/non-pressure skin areas with any deficiencies corrected at that time. 3.1: Director of Staff Development / designee re-in-serviced nursing staff on the proper procedure to follow regarding identification of a discoloration, skin tear, non-pressure areas when noted, as well as proper notification and monitoring of the area. The Unit Managers / designees will assess five (5) residents per unit weekly for six (6) months to ensure discolorations, skin tears, non-pressure areas have been identified and documented per policy. 4.1: The DON / designee will report audit findings completed by the Unit Manager/designee to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for	

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	bruising and increased size of bruises. A Nurse Practitioner Note, dated 6/16/21 at 5:37 p.m., indicated..."skin: multiple skin tears and ecchymotic areas varying in size to BUE and BLE...multiple skin tears- continue local tx [treatment]; geri-sleeves, tubigrips for protection..." The Physician's Order Summary, dated 6/2021, indicated an order for apixaban (Eliquis, a blood thinning medication) 5 mg (milligrams) twice a day for atrial fibrillation. The 6/2021 Medication Administration Record (MAR) indicated the resident had received the apixaban medication as ordered. The record lacked any documentation the discolorations to the resident's arms and right thumb/wrist/top of hand had been assessed and were being monitored. 2. On 6/15/21 at 11:24 a.m., Resident 37 was observed with a small open area to his right shin. There was no bandage to the area. On 6/16/21 at 10:02 a.m., the resident was observed seated in his room. The open area remained to his right shin and there was no bandage to the area. On 6/17/21 at 9:20 a.m., the resident was observed lying in bed with his eyes closed. The small open area remained to his right shin and there was no bandage to the area. Record review for Resident 37 was completed on 6/18/21 at 10:57 a.m. Diagnoses included, but were not limited to, venous insufficiency,		any trends and determine if further monitoring / action is necessary for continued compliance.	

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Parkinson's disease, and hypertension.

The Quarterly Change Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident was cognitively impaired. The resident required a 2+ person assist for dressing and personal hygiene. The resident was at risk for pressure ulcers.

A Care Plan indicated the resident was at risk for skin breakdown. An intervention included preventative skin care as ordered and skin inspection weekly as needed and to document and notify the Physician of abnormal findings.

A Wound Physician Note, dated 6/10/21, indicated an initial evaluation had been completed of an arterial wound to the right shin. The area was measured at 1cm (centimeter) x 0.5 cm x 0.1 cm. The recommendation was for a dry protective dressing to the area daily.

The Physician's Order Summary, dated 6/2021, lacked any treatment orders for the right shin area. The 6/2021 Treatment Administration Record (TAR) lacked any indication a treatment had been completed to the right shin area.

Interview on 6/18/21 at 1:49 p.m. with the Infection Prevention Staff Development Nurse, indicated the Wound Physician was doing rounds on 6/10/21 and observed the new area to the resident's right shin. He ordered a dry dressing to the area daily. The orders for the treatment had not been entered in the computer and they should have been.

3. On 6/14/21 at 11:06 a.m., Resident 127 was observed watching television in her room. She

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had multiple purple skin discolorations of varying sizes to both arms and hands.

On 6/16/21 at 9:44 a.m., the resident was observed eating breakfast. Multiple purple skin discolorations of varying sizes were observed to both arms and hands.

On 6/17/21 at 9:14 a.m., the resident was seated in her wheelchair in her room. Multiple purple skin discolorations of varying sizes were observed to both arms and hands.

Record review for Resident 127 was completed on 6/17/21 at 2:19 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, vascular dementia, and osteoarthritis.

The Admission Minimum Data Set (MDS) assessment, dated 5/20/21, indicated the resident was cognitively impaired. The resident required a 2+ person assist for dressing and toilet use, and 1 person assist with personal hygiene.

A Care Plan indicated the resident was at increased risk for bruising and bleeding due to use of antiplatelet medication and aspirin therapy. An intervention included to observe for signs of abnormal bleeding such as increased frequency of bruising and increased size of bruises.

The record lacked any documentation the discolorations to the resident's arms and hands had been assessed and were being monitored.

Interview on 6/17/21 at 11:04 a.m. with the DON indicated the skin discolorations should be assessed and monitored.

A facility policy, titled "Skin Management",

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	received as current from the DON, indicated "...8. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes...3. All alterations in skin integrity will be documented in the medical record...b) All newly identified areas after admission will be documented on the weekly pressure/non-pressure evaluation..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on record review and interview, the facility failed to ensure the safety of a resident related to not properly securing a resident's wheelchair during a bus transport for 1 of 4 residents reviewed for accidents. (Resident F) Finding includes: On 6/15/21 at 11:05 a.m., Resident F was observed lying in bed. The resident indicated she had an accident recently on the transport bus. The bus driver did not completely secure her wheelchair in place and her wheelchair tipped over. She had stayed in the wheelchair when it had tipped over	F 0689	The Facility respectfully requests a desk review. F689 1:1 Regarding resident F the Licensed Nurse assessed this resident. Physician was notified & X-rays were ordered. No injuries were noted. 2:1 The Director of Maintenance re-in-serviced the Care Team Member on the proper technique to use while ensuring residents who are transported by the facility bus are properly secured prior to	07/16/2021

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	and she hit her head on the floor of the bus. Record review for Resident F was completed on 6/16/21 at 1:10 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, diabetes mellitus, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 3/22/21, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist with bed mobility and transfers. A Care Plan indicated the resident was at risk for falls or fall related injury. An intervention included to assist with transfers. A Progress Note, dated 6/11/21 at 2:47 p.m., indicated at 1:00 p.m., the nurse received a call about the resident falling out of her wheelchair while on the bus. When the resident returned to the unit, a head to toe assessment was completed. The resident received a skin tear on her left thumb, abrasion to her right elbow and right mid portion of her back. She also had a bump to the right side of her head. Neuro checks were initiated and within normal limits. The Nurse Practitioner and the resident's Power of Attorney were notified. The resident had received several x-rays in the facility with no fractures observed. Interview with the Director of Nursing on 6/17/21 at 9:48 a.m., indicated the resident's wheelchair was not properly strapped on the bus when the resident was coming back from a dialysis appointment and the resident's wheelchair tipped over.		transporting. 3:1 The Director of Maintenance re-in-serviced the Transportation Care Team Members on the proper technique to use while ensuring residents who are transported by the facility bus are properly secured prior to transporting. The Director of Maintenance/designee will assess three (3) residents for proper safety techniques while in a w/c prior to being transferred by the facility bus for six (6) months. 4:1 The Director of Maintenance will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	155214	A. BUILDING 00 B. WING	06/18/2021

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	Interview with the Environmental/ Bus Driver 1 and the Maintenance Director on 6/17/21 at 11:40 a.m., indicated the bus the driver was driving that day was not the normal bus he drove. On the day of the incident he only strapped down one side of the wheelchair because he was unsure where the other strap was. The Maintenance Director indicated the bus driver had previously been shown where the straps were and should have asked for assistance in locating the other strap before transporting the resident. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis related to not assessing the resident's dialysis access site and not following a Physician's Order for fluid restrictions for 2 of 2 residents reviewed for dialysis. (Residents F and 32) Findings include: 1. On 6/15/21 at 11:05 a.m., Resident F was observed lying in bed. The resident had a bandage observed to her upper left arm. The resident indicated it was her dialysis access site.	F 0698	The Facility respectfully requests a desk review. F698 1:1 Regarding resident F the styrofoam cup/water pitcher was removed from this resident's room. The Physician was notified. No new orders were received. 1:2 Regarding resident F's dialysis access site it was assessed by the licensed nurse without concerns noted. The licensed nurse updated the dialysis order assessment set in Point Click	07/16/2021

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	There was a Styrofoam cup filled up with water, dated 6/14/21, on the resident's tray table. The resident indicated she was unsure if she had any fluid restrictions. On 6/15/21 at 3:40 p.m., Resident F was observed lying in bed. The Styrofoam cup was still observed on the resident's tray table. On 6/16/21 at 1:04 p.m., Resident F was observed sitting in a wheelchair in her room. She indicated she had just returned from a dialysis appointment. There was a Styrofoam cup of water, dated 6/16/21, on the resident's tray table. On 6/17/21 at 8:46 a.m., Resident F was observed lying in bed. A Styrofoam cup of water, dated 6/17/21, and another cup of water was observed on the resident's tray table. On 6/17/21 at 1:25 p.m., Resident F was observed lying in bed. The Styrofoam cup of water and the other cup of water was still observed on the resident's tray table. Record review for Resident F was completed on 6/16/21 at 1:10 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, diabetes mellitus, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 3/22/21, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist with bed mobility and transfers and supervision of 1 for eating. A Care Plan indicated the resident required hemodialysis on Monday, Wednesday, and Fridays. Interventions included to assess the		Care to the Facility policy. 2:1 The Nurse Managers/designees completed rounds on residents who require fluid restrictions to ensure the fluid restrictions are being followed. Any deficiencies were corrected at that time. 2:2 The Nurse Managers/designees assessed the residents who currently have a dialysis access site per the Facility policy. No concerns were noted. The Nurse Managers/designees completed chart audits on the residents requiring dialysis to ensure the dialysis order assessment set was in Point Click Care per the Facility policy. 3:1 The Director of Staff Development/designee re-in-serviced the staff regarding fluid restrictions & placement of styrofoam cups/water pitchers. The Nurse Manager/designee will complete random rounds on residents who require fluid restrictions to ensure the resident does not have a styrofoam cup/water pitcher in their room five (5) times a week on various shifts for six (6) months. 3:2 The Director of Staff Development/designee re-in-serviced the licensed staff regarding the required assessments of a dialysis catheter & the dialysis	

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	bruit and thrill (dialysis access site sound you can hear and sensation you can feel) every shift. A Care Plan indicated the resident was at a nutrition risk related to a therapeutic diet and on dialysis. Interventions included no water pitcher at bedside. A Care Plan indicated the resident was at risk for fluid imbalance due to end stage renal disease. Interventions included for a fluid restriction as ordered and no water pitcher at bedside. The June 2021 Physician's Order Summary (POS) indicated the following orders: - Dialysis on Monday, Wednesday, Friday: Order discontinued on 6/3/21. - AV Shunt Site: Monitor every shift for Thrill and Bruit; Order started on 11/19/20 and discontinued on 6/3/20. - Observe AV Shunt Site every shift for signs and symptoms of infection or bleeding; Order started on 11/19/20, and discontinued on 6/3/21. - 1200 ml (milliliters) fluid restriction. Dietary to provide 600 ml in 24 hrs. Nursing to provide 600 ml (am 200 ml), (pm 200 ml), (nights 200 ml). The resident was admitted to the hospital on 5/28/21 and returned to the facility on 6/7/21. The resident had orders prior to discharge to monitor the dialysis access site. The orders were not reinstated when she returned to the facility. There was no documentation to indicate the resident's dialysis access site was currently being monitored. Interview with the Director of Nursing (DON) on 6/16/21 at 3:56 p.m., indicated she would look into why the resident's dialysis orders were not started back up after her readmission from the hospital.		assessment order set in Point Click Care. The Nurse Manager will audit resident charts who require dialysis (3) times a week for six (6) months to ensure an assessment has been completed of the dialysis catheter site. 4:1 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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Interview with MDS Nurse 1 on 6/17/21 at 1:33 p.m., indicated the resident was on a fluid restriction and should not have a Styrofoam cup of water at her bedside. The resident's dialysis orders to monitor the access site should have been reinstated after her readmission from the hospital.

Interview with the DON on 6/17/21 at 4:21 p.m., indicated the resident should not have had the Styrofoam cup of water in her room every day if she was on a fluid restriction.
2. Interview with Resident 32 on 6/15/21 at 9:16 a.m., indicated she went to dialysis on Monday, Wednesday, and Friday. She had a fistula in her left arm for dialysis access but it wasn't working so they were currently using the catheter on her left chest.

The record for Resident 32 was reviewed on 6/16/21 at 9:03 a.m. Diagnoses included, but were not limited to, dependence on renal dialysis, anemia, and type 2 diabetes mellitus

A Quarterly Minimum Data Set assessment, dated 3/22/21, indicated the resident was cognitively intact and received dialysis.

A Care Plan indicated the resident received hemodialysis. The interventions included to observe for signs of infection to the access site and assess bruit (a sound created by blood flow through the fistula) and thrill (a vibration created by blood flow through the fistula) every shift.

The 5/2021 and 6/2021 Treatment Administration Records (TAR) and Medication Administration Records (MAR) lacked any monitoring or assessment of the left arm fistula or dialysis

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	catheter site. The Progress Notes, dated 6/2021, lacked documentation the dialysis access site had been assessed every shift. Interview with the DON on 6/16/21 at 2:14 p.m., indicated the dialysis access site should be assessed every shift. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents were free from	F 0757	The Facility respectfully requests a desk review.	07/16/2021

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	unnecessary medications, related to not checking a blood pressure prior to administering a blood pressure medication as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident F) Finding includes: Record review for Resident F was completed on 6/16/21 at 1:10 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, diabetes mellitus, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 3/22/21, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist with bed mobility, transfers, toilet use, and personal hygiene. A Care Plan indicated the resident was at risk for impaired cardiac output related to congestive heart failure, and hypertension. An intervention included to assess vital signs as ordered and indicated. The June 2021 Physician's Order Summary (POS) indicated the following order: - carvedilol (medication to treat high blood pressure) tablet 25 mg (milligrams) by mouth two times a day. Hold if systolic blood pressure (top number of blood pressure reading) is less than 90. The order was started on 6/8/21. The June 2021 Medication Administration Record (MAR) indicated, starting on 6/8/21, the resident received the carvedilol medication twice a day. There was no documentation to indicate the resident's blood pressure was checked prior to administering the medication.		F757 1:1: Regarding resident F, the Physician was notified regarding her BP & no adverse reactions were noted. 1:2: The Unit Manager/designee reviewed residents requiring parameters for BP medication for accuracy with any deficiencies noted corrected at that time. 1:3: Director of Staff Development/designee re-in-serviced licensed staff and QMAS regarding following physician's orders as well as following BP parameters. The Unit Manager/designee will audit five (5) residents per unit per week requiring BP parameters for accuracy for six (6) months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	Interview with MDS Nurse 1 on 6/17/21 at 2:13 p.m., indicated the staff should have checked and documented the resident's blood pressure readings before administering the medication. 3.1-48(a)(3)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Five errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 20%. (Residents 132 and 106) Findings include: 1. On 6/16/21 at 3:20 p.m., RN 2 was observed giving medications to Resident 132. The nurse administered his Wixela inhaler (an aerosol powder that contains a corticosteroid), completed care with the resident, and exited the room. She did not instruct the resident to rinse his mouth after the inhaler. During an interview with RN 2 on 6/16/21 at 4:30 p.m., the Wixela package was observed and indicated to rinse mouth after use. The nurse indicated she should have completed oral care with the resident at that time.	F 0759	The Facility respectfully requests a desk review. F759 1:1: Regarding resident #132, the licensed nurse assessed this resident without any findings. The Physician was made aware of the medication error & no new orders were obtained. Regarding resident #106, the licensed nurse assessed this resident without any findings. The Physician was notified of the unavailable medication, BP parameters, & the medication was reordered from the Pharmacy. 1:2 The DON re-in-serviced the licensed nurse regarding the protocol after administering an aerosol powder that contains a corticosteriod. No other residents were affected at that time. The Nurse Manager re-in-serviced the licensed nurse on reordering medication & notifying the	07/16/2021

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	2. On 6/17/21 at 8:05 a.m., LPN 4 was observed preparing medications for Resident 106. Three medications she was scheduled to receive could not be located in the medication cart; famotidine, dicyclomine and tolterodine. The resident received a total of ten pills, including midodrine (for blood pressure). There was no further action regarding the missing medications by LPN 4 until questioned after med pass. The LPN indicated the three missing medications would be reordered from the pharmacy at that time. The resident's record was reviewed 6/17/21 at 10:00 a.m. A Physician's order dated 1/7/21, indicated to give midodrine 2.5 milligrams three times daily for hypertension, but to hold the medication if the systolic blood pressure (BP) (top number) was less than 140. The last recorded BP was on 6/16/21 at 10:02 p.m., and was 111/81. There was no BP recorded prior to the administration of midodrine on 6/17. Nursing Notes, dated 6/17/21, lacked documentation the Physician had been notified the resident had not received the famotidine, dicyclomine or tolterodine medications. During an interview with the Director of Nursing on 6/17/21 at 10:00 a.m., she indicated the Physician and pharmacy should be notified if medications were not available and the the resident had not received them. 3.1-48(c)(1)		Physician when medication is not available as well as following BP parameters when administering medication. 1:3: The Director of Staff Development/designee re-in-serviced the Licensed Staff & Qualified Medication Assistants on how to reorder medication, notification of the Physician if medication is unavailable, BP parameters, & following physician's orders. The ADON/designee will complete a random medication pass with two (2) Licensed Staff or Qualified Medication Assistants weekly for six (6) months to ensure accurate medication administration/medication availability/following physician's orders. 1:4: DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor data presented for any trends & determine if further monitoring /action is necessary for continued compliance.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation and interview, the facility failed to distribute fluids under sanitary conditions related to beverages uncovered during serving of the 2nd floor unit room trays. This had the potential to affect 11 of 41 residents who received room trays. (2A Hall and 2B Hall) Findings include: 1. During an observation of lunch service on 6/14/21 at 12:16 p.m., CNA 2 was observed on the 2A Hall. She had poured drinks of different fluids and placed them uncovered on 10 trays on the also uncovered food cart. She then proceeded to wheel the cart down the hall to distribute the trays to the residents. 2. During an observation of lunch service on 6/14/21 at 12:25 p.m., LPN 2 was observed on the 2B Hall. She had poured coffee and juice and placed them uncovered on a food tray. She then	F 0812	The Facility respectfully requests a desk review. F812 1:1: Regarding residents who received room trays on the 2 floor, no adverse reactions were noted. 1:2: Unit Managers/designees made rounds on the lunch/dinner room tray passes on all units to ensure drinks/food was covered when transporting food trays in the hallway. Unit Managers/designees re-in-serviced the staff on the 2 floor regarding infection control practices of covering all drinks/food when transporting the food trays in the hallway. 1:3 The Director of Staff Development/designee	07/16/2021

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	proceeded to walk down to the end of the hallway to deliver the resident's room tray. Interview with CNA 2 on 6/14/21 at 12:21 p.m., indicated she was aware the drinks needed to be covered before taking them down the hall. She did not have any lids and thought the kitchen should send the drinks up already covered. Interview with LPN 2 on 6/14/21 at 12:27 p.m., indicated she was aware the drinks needed to be covered before taking them down the hall but had forgotten. She then proceeded to get out plastic lids to cover the drinks. Interview with the Director of Nutrition Services on 6/15/21 at 1:45 p.m., indicated staff was aware the drinks were supposed to be covered when they are taken down the hallways. The staff were also aware of where the lids were located on the kitchen units. 3.1-21(i)(3)		re-in-serviced the staff regarding the proper infection control procedures when delivering resident room trays. Unit Mangers/designees will audit five (5) resident room tray deliveries per unit weekly for six (6) months to ensure drinks/food are covered while maintaining infection control guidelines. 1:4: DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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(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
	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly in isolation rooms, not following aerosol generating procedure (AGP) guidelines, and staff not aware of which rooms were on isolation, for random observations on the 2D hall (yellow zone). The facility also failed to ensure infection control guidelines were followed related to storage and replacement of a nebulizer kit for 1 of 1 residents reviewed for respiratory care (Resident 212) and not changing an enteral feeding tubing as ordered for 1 of 1 resident reviewed for tube feeding. (Resident 132) Findings include: The following observations were made on the 2D hall. The doors to the hall were closed and there were signs on the doors that indicated it was a Yellow zone, (COVID-19 status unknown,	F 0880	F880 Quality Improvement Initiative (Intervention and Improvement Plan) Tool QII ID: Directed Plan of Correction: Infection Prevention and Control Email non PHI information to: kdawson@qsource.org (Kara Dawson) Provider Contact: Kara Dawson Phone: 317-628-1145 Title: Quality Improvement Advisor / Infection Preventionist Consultant Email: kdawson@qsource.org	07/16/2021

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	observation isolation) and PPE required to enter rooms were a face mask, face shield, gown, and gloves. 1. On 6/15/21 at 8:27 a.m., Resident 212 was observed lying on her bed in her room, she had a nebulizer mask (a mask used to deliver breathing treatments) on her face that was in use. There was a small red sign on the side of her door that indicated she was on droplet and contact precautions and there was an isolation cart outside of her room. At 8:34 a.m., RN 1 entered the resident's room, without donning a gown or gloves, and shut the door. She exited the room a few minutes later. Interview with RN 1 at 8:37 a.m., indicated she was aware she should have put on a gown and gloves before entering the room. She indicated she was not aware the room door should have been closed while a resident received an AGP and should remain closed for an hour afterward. Interview on 6/15/21 at 9:05 a.m. with Respiratory Therapist 1, indicated she was not aware that the doors needed to be closed during and an hour after AGPs. She thought those guidelines had been lifted. The IDOH guidance, "Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination," dated 6/1/21, indicated, ".... AGPs in Red/ Yellow zones: Limit performance of aerosol-generating procedures (AGPs) on confirmed or presumed COVID-19 positive residents unless medically necessary. For any AGP that is performed on a resident with COVID or suspected COVID they should be performed in a private room with full Transmission-Based Precautions [TBP] with the door closed for		Department: Qsource Fax: Page Break Instructions for Section I: Writing an Aim Statement It is necessary for your facility to have a clear Aim Statement when you identify an opportunity for improvement, either based on your discovery or information provided to you. It is important that you establish a measurable objective, which we refer to as Aims or Goals. The Aims/Goals are what you want to accomplish during a quality improvement initiative. This should be clearly stated, quantifiable, and represent a challenge for your facility. An example of an Aim Statement is: “Increase the number of staff appropriately washing hands per infection prevention protocol by ___% by ______________ (date).” Quality Improvement Initiative 1.Aim Statement: Staff will adhere to the facilities infection control policies and procedures as it relates to donning and doffing of PPE, equipment storage, labeling and replacement at a compliance rate of 90% by December 31, 2021. 1.Provider Name: St. Anthony	

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	duration of procedure and 1 hour after the procedure ends. This includes N-95 mask, eye protection, gown and gloves and keeping the door closed throughout the procedure and disinfecting all surfaces following the procedure ...." 2. On 6/15/21 at 8:50 a.m. RN 1 was observed in Room 296 talking to the resident without a gown or gloves on. Interview with the RN at that time, indicated the resident was not on isolation precautions. She indicated there were only three residents on the hall who were on isolation, the rooms that had isolation carts in front of them. The RN indicated she was an agency nurse and only worked that hall on occasion. She indicated she needed clarification and made a phone call. She then indicated she was told all rooms on the hall were contact/droplet isolation. Interview with CNA 6 on 6/15/21 at 8:55 a.m., indicated she was agency and it was the second time she had worked on this hall. She thought the rooms with the isolation carts in front of them were the only rooms on isolation. Interview with the IPSD (Infection Preventionist Staff Development) Nurse on 6/17/21 at 11:00 a.m., indicated she was responsible for training agency staff. She indicated everyone on the Yellow unit was considered to be on isolation and this should have been communicated. Doors should be closed during an AGP and staff needed to be aware of that. She was aware of the confusion and indicated she was working to correct it. 3. On 6/14/21 at 1:37 p.m., Resident 212 was observed in her room. Her nebulizer mask was		Home Provider #: 155214 1.Identify improvement team members: (include name and title) ·Cathy Wood – Director of Nursing ·Dean Ramsey - Administrator ·Cheryl Young – Infection Preventionist ·Wendy Whitkanack – Staff Development ·Amy Wenk – Assistant Director of Nursing ·Adam Anderson – Regional Infection Preventionist Do you have a physician champion(s)? ¿ Yes ¿ No Name(s): Dr. William Bisset Who is the lead team member? Cathy Wood 1.Provide a description of the root cause of the concern(s) identified: ·Problem Statement: Facility failed to ensure that staff were donning/doffing appropriate PPE when entering residents rooms that were on isolation precautions ·Staff entering residents room that was marked as contact and droplet isolation precautions without donning PPE ·Lack of knowledge/adherence	

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	lying on her nightstand on a paper towel. On 6/16/21 at 8:47 a.m., the nebulizer mask was wrapped in a paper towel and sitting in the nightstand drawer. On 6/17/21 at 9:10 a.m., the nebulizer mask was lying on the nightstand. There was not a date on the mask or tubing. The resident's record was reviewed on 6/16/21 at 1:55 p.m. The resident was admitted on 6/7/21. A Physician's order, dated 6/8/21, indicated ipitroprium/albuterol .5/ 2.5 milligrams per 3 milliliters four times daily via nebulizer. There was no order related to scheduled changing of the nebulizer tubing or mask. Interview with the DON on 6/17/21 at 10:00 a.m., indicated nebulizer masks should be changed every week and stored in a plastic bag. She was not aware there was not an order in place to change the mask and tubing every week. The facility policy, "Departmental (Respiratory Therapy)-Prevention of Infection", was provided by the DON (Director of Nursing) on 6/18/21 at 10:10 a.m., and indicated, "...Infection Control Considerations Related to Medication Nebulizers...7. Store the circuit in plastic bag, marked with date and residents name between uses...9. Discard the administration "set up" every seven (7) days...." 4. On 6/16/21 at 8:55 a.m., Resident 132 was observed in his bed. He was receiving a continuous enteral tube feeding. The tubing from his container of tube feeding was dated 6/14. On 6/17/21 at 9:15 a.m., the tubing was still dated 6/14. The resident's record was reviewed on 6/16/21 at 1:30 p.m. The resident was admitted on 6/12/21. He had a gastrostomy tube inserted into his		to facilities policies and procedures regarding use for PPE for residents requiring isolation precautions ·Need for re-education and increased monitoring on appropriate donning and doffing of PPE ·Problem Statement: Staff failed to ensure that doors were closed during AGP treatments and for one hour after ·Resident receiving AGP and room door was open ·Staff lack of knowledge/adherence regarding facilities current policy and procedure related to keeping door closed during and for one hour after any Aerosol Generating Procedure. ·Need for re-education and increased monitoring on current AGP policy and procedures. ·Problem Statement: Facility failed to ensure that equipment was labeled, stored and replaced according to facility policy and procedure. ·Nebulizer tubing being stored on paper towel on bedside table with no date on tubing or mask and no order to indicate the frequency for changing the mask and/or tubing. ·Tubing for feeding not changed per facility policy and procedure. ·Staff lack of knowledge/adherence to facilities policy and procedure regarding	

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	stomach to receive nutrition. A Physician's order, dated 6/12/21, indicated to change the container, tubing, and syringe every 24 hours on midnights. Interview with RN 3 on 6/17/21 at 9:15 a.m., indicated she was unaware the tubing had not been changed as ordered. 3.1-18(b)		labeling, storing and replacing tubing and resident equipment (mask, etc). ·Need for re-education and increased monitoring to ensure resident equipment is being stored, dated and replaced according to facilities current policy and procedure. ·Problem Statement: Facility failed to ensure that immunizations (Pneumococcal) were administered timely and that frequent education was continued to be given to those residents who refused a vaccination ·New resident received education regarding pneumococcal vaccination and consent obtained ·Staff failed to ensure that the vaccination was administered in a timely fashion after consent was obtained ·Staff failed to ensure that routine education was given to those residents who had initially refused the vaccination ·Lack of knowledge/adherence to facilities policy and procedure for vaccinations ·Need for re-education and increased monitoring to ensure residents are offered vaccinations that are needed, educated and given the vaccination in a timely manner. ·Need for re-education and increased monitoring to ensure that residents that initially refused	

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			vaccination are given education on a routine basis. 1.Describe in detail interventions you plan to implement to address the identified concern(s). You may attach any supporting documents, including revised procedures, monitoring process, approval process, evaluation process, etc. Based on a review of recent infection control deficiencies on complaint surveys and corrective action that are being implemented with the plan of correction the following interventions were identified as opportunities to ensure that all systems continued to remain in place and are being followed according to the facilities policies and procedures. Project Plan ·Perform a Root Cause Analysis and develop/implement needed solutions/system changes to address findings within the RCA – July 7, 2021 ·In-services ·Overview of proper donning and doffing of PPE – July 16, 2021 ·When to don and doff PPE ·Sequence of donning and doffing of PPE ·Equipment Storage, labeling	

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			and replacement – July 16, 2021 ·Storage of nebulizer masks and other resident tubing/equipment when not in use ·Review of facilities policy and procedure ·Labeling/Dating of tubing ·Frequency for changing out residents equipment (mask, tubing, etc) ·Infection Control Overview – in-service along with PowerPoint and Pre/Post Test will be provided by QIO/Infection Preventionist ·Bi – annual Infection Control education/in-services will be performed for all staff including a general overview as well as, specific infection control guidelines for each department within the facility ·Orientation – in addition to the required infection control training will implement departmental specific infection control guidelines for each department within the facility. ·Monitoring Tools to be completed to ensure infection control practices are being followed ·Appropriate donning and doffing of PPE,– five times a week for 6 weeks then monthly until end of project ·Appropriate storage, labeling/dating and changing of resident equipment (nebulizer mask) and/or tubing – five times a week for 6 weeks then monthly	

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			until end of project ·Facility will implement this monitoring on a routine quarterly basis ·Quarterly monitoring will be random and will cover all shifts ·Completed audits will be presented and reviewed in routine QAPI meetings ·Return Demonstration of Donning and Doffing of PPE will be conducted on July16, 2021 with all staff and will then be conducted on an annual basis or as needed if deficiencies are present as a result of quarterly monitoring. ·Resources from QIO on an ongoing basis throughout the project time period. Initial resources will include (but not limited too) ·PPE Sequencing Guide ·Infection Control In-service recorded link along with PowerPoint and Pre/Post Test ·Monitoring Tools (PPE) 1.Specify start date of interventions, projected date of completion and key interim implementation dates, if there are multiple steps to full implementation. ·Start Date – July 7, 2021 ·End Date - December 31, 2021 1.List date(s) that improvement implementation will be evaluated. ·Midway Check Point –September 2021	

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			·Final Check and Wrap Up – December 2021 1.Describe in detail how you will check progress: (include your plan for interim monitoring of cases) ·Touch base meetings – onsite ·July 16, 2021 ·December 2021 ·As needed and/or requested throughout the project ·Review of monthly monitoring tools by QIO – (facility to send completed monitoring tool to QIO contact monthly) ·August 28, 2021 ·September 28, 2021 ·October 28, 2021 ·November 28, 2021 ·December 28. 2021 ·Evaluation of processes during midway check point 1.If needed, indicate when alternative measures would be instituted: (trigger or projected timeline) ·Alternative measures will be instituted immediately if indicated by non-compliance ·Need for alternative measures would be evaluated through completed audits on a monthly basis 1.Describe actions you will implement if original corrective measures are ineffective: ·Will meet with project team to discuss and perform an additional	

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			RCA ·Start performance improvement plan according to results of RCA Your final report should include answers to the following questions: (This will be reviewed during final meeting in March 2022) 1.Did you achieve your stated goal? (Please include a brief description of where you were and where you are now after QII conclusion) 1.Would you consider the improvement project you just completed a success? If “yes”, please explain why. If “no”, please explain and/or provide any barriers that may have prevented you from achieving the level of success you envisioned at the start. 1.Did your experience lead to changes in the current protocols? 1.Do you have any new protocols related to this improvement project that you are willing to share with others?	
F 0883 SS=D	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations			

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Bldg. 00	§483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is			

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	medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to annually provide education to the resident or the resident's representative on the Influenza and Pneumococcal Immunizations (injections to help prevent a the Flu virus and lung infection), failed to provide the Pneumococcal Vaccine after consent was given, and administered an Influenza Vaccine without providing education and obtaining a consent for 3 of 5 residents reviewed for Infection Control. (Residents 9, 32, and 115). Finding includes: Residents 9, 32 and 115's records were reviewed on 6/17/21 at 9:06 a.m. Resident 9 was admitted into the facility on 9/2/20. A consent form and education for the Pneumococcal Vaccine was given and signed on 9/2/20. The Immunization Record indicated the Pneumococcal Vaccine had not been administered.	F 0883	The Facility respectfully requests a desk review. F883 1:1 Regarding residents #9 & #32 no adverse reactions were noted from not receiving the Pneumococcal immunization. Physician & RP were made aware. New orders received. Education was provided to the resident & RP regarding the Pneumococcal immunization. Consents were signed & both residents received the Pneumococcal immunization. Regarding resident #115 education was provided to the RP regarding benefits/potential side effects & at this time declined the Pneumococcal immunization. 1:2 The Director of MDS/designee audited resident charts to ensure education was provided to the resident/RP regarding the	07/16/2021

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	Resident 32 was admitted into the facility on 9/24/20. A consent form and education for the Pneumococcal Vaccine was given and signed on 9/24/20. The Immunization Record indicated the Pneumococcal Vaccine had not been administered. Resident 115 was admitted into the facility on 7/12/18. Education and refusal of the Influenza and Pneumococcal Vaccines was signed on 10/11/18. There was no further education and consent/refusal for the Influenza and Pneumococcal Vaccines provided to the resident and/or family located in the record. The Immunization Record, indicated the Influenza Vaccine had been administered on 11/5/20. During an interview on 6/17/21 at 1 p.m., the Director of Nursing indicated she could not find documentation that the Pneumococcal Vaccinations had been administered after consent obtained. During an interview on 6/18/21 at 8:30 a.m., the Director of Nursing indicated she could not find a signed consent and education for the Influenza Immunization for Resident 115. 3.1-13(a)		Pneumococcal immunization. Acceptance or declination was received for the residents who have not been previously immunized. Administration of the immunization was documented in the resident's clinical record. The Director of Staff Development re-in-serviced the staff regarding the need for resident or RP education on the benefits, potential side effects of the pneumococcal/influenza immunization, as well as the required documentation when administering the immunization. 1;3 The Director of Admissions/designee will inform the resident/RP regarding the benefits of the pneumococcal/influenza immunization, the potential side effects of the pneumococcal/influenza, as well as obtaining a consent or declination at the time of admission. The acceptance or declination forms will be scanned into Point Click Care. The Nurse Manager/designee will audit new admissions to ensure the pneumococcal & influenza (when applicable) immunization acceptance/declination forms have been completed & the immunization is given if consented for six (6) months. 1:4: DON/designee will report audit findings to the QAPI committee monthly for six (6)	

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			months. The QAPI committee will monitor data presented for any trends & determine if further monitoring /action is necessary for continued compliance.	
F 9999 Bldg. 00	1. 3.1-37 Quality of Care (a) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan. This state rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident received necessary care and services, related to assessment of a dialysis access site (arterial venous fistula) and dressing change, for 1 of 2 residents reviewed for necessary care and services in NCC (Non-certified Comprehensive Care) beds. (Resident 1) Finding includes: During an observation on 6/18/21 at 8:52 a.m., there was a dressing covering an area on the resident's upper right arm. Resident 1's record was reviewed on 6/17/21 at 1:52 p.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, dementia, PVD (peripheral vascular disease). A Significant Change Minimum Data Set	F 9999	The Facility respectfully requests a desk review. F9999 1:1 Regarding resident #1's dialysis access site it was assessed by the licensed nurse without concerns noted. The licensed nurse updated the dialysis order assessment set in Point Click Care to the Facility policy. 2:1 The Nurse Managers/designees assessed the residents who currently have a dialysis access site per the Facility policy. No concerns were noted. The Nurse Managers/designees completed chart audits on the residents requiring dialysis to ensure the dialysis order assessment set was in Point Click Care per the Facility policy. 3:1 The Director of Staff Development/designee re-in-serviced the licensed staff regarding the required assessments of a dialysis catheter & the dialysis assessment order set in Point	07/16/2021

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	155214	A. BUILDING 00 B. WING	06/18/2021

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

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	assessment, dated 3/16/21, indicated the resident was cognitively intact and received dialysis. A Care Plan, dated 12/4/21, indicated the resident required hemodialysis. The interventions included, to assess the dialysis access site every shift and to check and change the dressing over the site daily. A Physician's Order, dated 10/26/20, indicated dialysis was scheduled for every Monday, Wednesday, and Friday. There was no assessment of the dialysis access site in the Nurses' Progress Notes, dated 6/1/21 through 6/17/21. There was no assessment or dressing change completed on the Medication and Treatment Administration Record, dated 6/2021. During an interview on 6/17/21 at 4:19 P.M., the Director of Nursing indicated the dialysis access site was to be assessed every shift. During an interview on 6/18/21 at 8:50 a.m., LPN 3 indicated the dialysis access sites were monitored on dialysis days, unless there was bleeding at the site. During an interview on 6/18/21 at 9:21 a.m., Resident 1 indicated the only time the staff looked at the dialysis site and changed the dressing was on dialysis days. 2. 3.1-38 Activities of Daily Living (a) Based on the comprehensive assessment of a resident and the care plan, the facility must ensure the following: (3) A resident who is unable to carry out ADL		Click Care. The Nurse Manager will audit resident charts who require dialysis (3) times a week for six (6) months to ensure an assessment has been completed of the dialysis catheter site. 4:1 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:2 Regarding resident #1 the licensed nurse assessed this resident without any adverse reactions noted. 2:2 The Nurse Manager/designee audited the timeliness of staff answering the resident's call lights & providing care to the residents without concerns noted. 3:2 The Director of Staff Development/designee re-in-serviced the staff on answering the resident's call lights timely & providing care upon answering the call light. If the staff is unable to assist the resident, they will find a staff member who can provide care. The Nurse Manager/designee will complete random audits of the staff answering a resident's call	

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	receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Each resident shall show evidence of good personal hygiene, including, but not limited to, the following: (A) Care of the skin. This state rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident who required extensive to total care, received care in a timely manner, related to incontinent care after a bowel movement, for 1 of 2 residents observed for incontinent care in NCC (Non-certified Comprehensive Care) beds. (Resident 1) Finding includes: During an interview and observation on 6/18/21 at 9:18 a.m. through 9:30 a.m., the call light for the resident's room had been activated. Resident 1 indicated he had been incontinent of bowel movement. He indicated when the call light was activated, the staff would come in and ask what he needed, he had told them he had been incontinent of bowel movement. They would turn the call light off and told him they would return. They had not returned for care to be provided. CNA 3 then entered the room and the resident informed her he needed to be "changed". The CNA informed the resident she was picking up breakfast trays and she would return to provide care, then left the room. The resident then indicated he had been incontinent for 8-10 hours. CNA 4 then entered the room, she indicated this was the first time she had been made aware the resident required care. She indicated she had not provided care for the resident since she started her shift at 6:30 a.m. While CNA 4 prepared the washcloths and brief,		light & providing prompt assistance five (5) times a week per unit for six (6) months. 4:2 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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Resident 1 was moaning. He indicated he was in pain and the pain was in his crotch area. He then indicated he told the staff when he was incontinent, that he was in pain and the pain was in the crotch area. The staff told him they would be back, then they waited for the next shift to start. "It had been a long time and now my crotch is really sore". CNA 3 then returned to the room and indicated she started work at 6:30 a.m. She indicated the resident would have been the last resident checked by the Night Shift CNA. CNA 4 then removed the brief and began incontinent care. The resident had been incontinent of a large soft bowel movement, which was on the buttocks and the scrotal area. The scrotum was red and excoriated and the resident moaned out in pain when CNA 4 was washing the area. The area around the anus was red and the resident continued to moan out in pain with cleansing. CNA 4 used several strokes to clean the bowel movement off the buttock, scrotal, and groin area. CNA 4 then applied barrier ointment. CNA 3 indicated the bowel movements had "acidity" and his skin would be red often.

Resident 1's record was reviewed on 6/17/21 at 1:52 p.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, dementia, PVD (peripheral vascular disease).

A Significant Change Minimum Data Set assessment, dated 3/16/21, indicated the resident was cognitively intact, required extensive assistance of two staff for bed mobility and hygiene, was dependent on two staff for transfers, toileting, and bathing, was incontinent of urine and frequently incontinent of bowel.

A Care Plan, dated 12/4/20, indicated the resident

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	was incontinent. The interventions included to check routinely for incontinence and care was to be provided.			