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	08/11/2023

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 the Investigation of Complaint IN00414807. Complaint IN00414807 - Federal/state deficiencies related to the allegations are cited at F607 and F609. Unrelated deficiencies are cited. Survey date: August 11, 2023 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 151 SNF: 26 NCC: 3 Total: 180 Census Payor Type: Medicare: 24 Medicaid: 119 Other: 37 Total: 180 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/15/23.	F 0000		
F 0607 SS=D Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that:			

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

Jami Moore | HFA | 08/31/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on observation, record review, and interview, the facility failed to implement their written policies and procedures that protected residents after an allegation of abuse, related to a CNA continued to work the rest of the shift after an allegation of abuse was reported by a resident for 1 of 3 residents reviewed for abuse. (Resident B and CNA 2) Finding includes:	F 0607	The corrective actions that were accomplished for those residents to have been affected the practice are: was reported and investigated. Staff suspended pending an investigation. in stable condition and experienced no negative outcomes as a result of this observation.	09/01/2023

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	During an interview on 8/11/23 at 4:37 a.m., Nurse 1 indicated an altercation had occurred between staff members and Resident B on 8/8/23. Resident B accused CNA 2 of throwing water on her. The Director of Nursing (DON) was notified and CNA 2 was removed from the resident's care. CNA 2 had not been sent home and worked the rest of her shift. Cross reference F609 The facility abuse policy, dated 3/2021 and received from the Director of Nursing as current, indicated employees who have been accused of resident abuse shall be suspended of duty immediately until the results of the investigation have been reviewed by the Administrator. This Federal tag relates to Complaint IN00414807. 3.1-28(a)		How other residents of the facility were identified to potentially be affected by the practice are: All residents have potential to be affected by this deficiency. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: All staff were educated on abuse policy and reporting abuse. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: Executive Director or Designee will interview (5) residents (5) per week for 6 months to ensure incidents of allegations of abuse are managed according to facility policies and federal regulations. Executive Director/Designee will report audit findings to the QAPI committee monthly for (6) six 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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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) and other proper authorities for 1 of 3 residents reviewed for abuse. (Resident B)	F 0609	The corrective actions that were accomplished for those residents to have been affected the practice are: was reported and investigated.	09/01/2023

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	Finding includes: During an interview on 8/11/23 at 4:37 a.m., Nurse 1 indicated an altercation had occurred between staff members and Resident B on 8/8/23. Resident B had several outbursts of yelling at staff. CNA 2 was in the room and she was in the hallway. She heard something that sounded like an object sliding across the floor "like it had been thrown". When she entered the resident's room, Resident B accused CNA 2 of throwing water on her and there was a bath basin on the floor. CNA 2 indicated the resident had thrown water on her. The Director of Nursing (DON) was notified and CNA 2 was removed from the resident's care. The resident was mad and would not let anyone complete care on her. During an observation on 8/11/23 at 4:55 a.m., Resident B was awake, sitting up in bed, the TV was on, and she was doing something on her cell phone. She agreed to be interviewed and indicated a CNA had thrown a glass of water at her earlier in the week. The CNA had not been back in her room to care for her. She notified the Police about the incident and someone from the Police Department had come and spoken to her. During an interview on 8/11/23 at 6:35 a.m., the DON indicated the allegation the CNA had thrown water at the resident was not reported to her. It was reported that there were concerns and the resident was having behaviors. She was aware the Local Police Department had been notified by the resident. During an interview on 8/11/23 at 8:15 a.m., the Executive Director indicated the allegation had not		Staff suspended pending an investigation. in stable condition and experienced no negative outcomes as a result of this observation. How other residents of the facility were identified to potentially be affected by the practice are: All residents have potential to be affected by this deficiency. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: All staff were educated on abuse policy and reporting abuse. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: Executive Director or Designee will interview (5) residents (5) per week for 6 months to ensure incidents of allegations of abuse are managed according to facility policies and federal regulations. Executive Director/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any	

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	been reported to her. It was reported that the resident threw water on the CNA. The Police Report was reviewed on 8/11/23 at 9:07 a.m. and indicated the Police had arrived on 8/8/23 at 2:39 a.m. The resident had made an allegation a cup of water had been thrown on her by a CNA. She had asked for a glass of water and the CNA had gone to get the water and the resident then activated her call light again due to the need to use the bathroom. The CNA was mad and threw the cup of water at her and it hit her in the face. The bed was observed wet with a few ice cubes observed. Her face and hair were not wet. The chief complaint was listed as abuse and a CNA was abusing her and threw some ice water at her face. During an interview on 8/11/23 at 9:26 a.m., CNA 2 indicated the resident placed her call light on, she answered the light and the resident was rude and said she needed ice water. CNA 2 obtained the ice water and brought it back to her. She then said she needed the bedpan and she was informed that supplies were needed and the CNA left the room to get them. When she returned 5-10 minutes later the resident was cursing and wanted to know what took her so long. The resident then threw the bath basin at her. The CNA stopped what she was doing and informed the resident she would be back and at that time the Resident threw the water at her. The CNA then left the room. During an interview on 8/11/23 at 9:40 a.m., the DON indicated the Nurse and the CNA had written a statement on 8/8/23 and there was nothing in the statement about the CNA throwing water in the resident's face. A signed statement by the DON, dated 8/8/23,		trends & determine if further monitoring/action is necessary for continued compliance.	

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	indicated the Nurse notified her that the resident had called the Police in regards to a care complaint. It was reported to the nurse by the CNA that the resident threw a wash basin and a cup of water at the CNA. When the Nurse entered the room, the wash basin and water were observed on the floor near the doorway. A signed statement by Nurse 1, dated 8/8/23, indicated at approximately 1:30 a.m., she was in the hallway and heard Resident B yelling. CNA 2 was exiting the room and stated the resident had asked for ice. Nurse 1 entered the room and the resident reported to her the CNA had thrown ice water in her face. The CNA reported the resident had thrown a bath basin and a cup of ice water at her. the resident was screaming that the CNA was liar, she was going to call the Police, and refused any care offered to her by the Nurse. She was screaming at the staff to get out of her room. The DON was notified. Resident B's record was reviewed on 8/11/23 at 7:16 a.m. The diagnoses included, but were not limited to, depression. An Admission Minimum Data Set assessment, dated 7/17/23, indicated an intact cognitive status and physical behaviors, verbal behaviors, other behaviors, and rejection of care occurred one to three days. There was no documentation of the incident/allegation that occurred on 8/8/23 in the Progress Notes. A facility abuse policy, dated 3/2021, received from the DON as current, indicated when an alleged or suspected care of mistreatment or abuse was reported the Administrator, DON or			

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	designee would immediately notify the State licensing/certification agency (IDOH), the attending Physician, the Resident Representative, and any agencies as required (Adult Protective Services). This Federal tag relates to complaint IN00414807. 3.1-28(c)			
F 0743 SS=D Bldg. 00	483.40(b)(2) No Behavior Difficulties Unless Unavoidable §483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; Based on record review and interview, the facility failed to accurately document behaviors, triggers for the behaviors, interventions, and the outcome of the interventions for the behaviors, for 1 of 3 residents reviewed for behaviors. (Resident B) Finding includes: Resident B's record was reviewed on 8/11/23 at 7:16 a.m. The diagnoses included, but were not limited to, depression. An Admission Minimum Data Set assessment, dated 7/17/23, indicated an intact cognitive status, and physical behaviors, verbal behaviors, other behaviors, and rejection of care occurred one to three days.	F 0743	The corrective actions that were accomplished for those residents to have been affected the practice are: Resident psych provider and facility social services provided with psychosocial support. in stable condition and experienced no negative outcomes as a result of this observation. How other residents of the facility were identified to potentially be affected by the practice are: All residents with behavioral	09/01/2023

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	A Care Plan, dated 7/11/23 and revised on 8/9/23, indicated behaviors exhibited were refusals of care, medications/treatments, she dictated her care with the staff what she wants/doesn't want and what she will or won't do, demanding of staff when wants/needs could not be accommodated, threatened staff that she will "just go home", has made multiple complaints about care, exhibited a rude/unpleasant demeanor, has been manipulative like making a request then refusing and then told others it was never offered, and has had false/unfounded statements. The interventions, dated 7/11/23, were as follows: The resident would be allowed to vent feelings and needs. She was to be approached in a calm and friendly manner. Her needs were to be assessed for food, thirst, toileting, comfort levels, positioning, pain, etc and they would be treated as indicated. Attempts would be made to guide/educate on facility procedures and promote compliance so her wants/needs could be met. The behaviors would be documented per the behavior management program. The staff would explain what they were going to do before initiating the task. The resident would be given as many choices as possible about care and activities. The behavior triggers would be identified and the exposure to the triggers would be reduced. If she was angry and inconsolable, the room was to be left and she was to be re-approached at a later time. The Physician and Psychological Services were to be notified for increased behavioral symptoms. Psychological Services were to be provided as ordered.		symptoms have potential to be affected by this deficiency. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: All staff were on behavioral documentation to include triggers and interventions. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON or Designee will review clinical dashboard (5) per week for 6 months to ensure documented behaviors have follow-up nursing progress notes. DON/Designee will report audit findings to the QAPI committee monthly for (6) six 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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	The Behavior Log indicated the following: - On 7/14/23 there were behaviors of yelling/screaming, pushing, grabbing, pinching, abusive language, threatening behavior, and rejection of care. - On 7/23/23 there was a behavior of abusive language. - On 8/2/23, there were behaviors of yelling, screaming, abusive language, threatening language, and rejections of care. - On 8/8/23, there were behaviors of yelling, screaming, abusive language, and rejection of care. The behaviors were not documentation in the Progress Notes or any other areas of the record that indicated the behaviors occurred, triggers of the behaviors, what was occurring at the time of the behaviors, the interventions attempted and the outcome of the interventions provided. During an interview on 8/11/23 at 12:22 p.m., Social Service 3 acknowledged there was no documentation of the behaviors, the triggers, interventions, and the effectiveness of the interventions other than the Behavior Log. The facility behavior management policy, dated 4/2022 and received from the Executive Director as current, indicated the residents were provided a supportive environment with interventions that are specific to the resident's individualized needs. All altercations would be reviewed by the Interdisciplinary Team, as they were considered worsening behaviors. The Interdisciplinary Team would evaluate the interventions and attempts would be made to determine an underlying cause. 3.1-43(a)(1)			

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