STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0000	This visit was for the Investigation of Complaint IN00114043. Complaint IN00114043-Substantiated. Federal/state deficiency related to the allegation is cited at F246. Survey dates; August 17 & 20, 2012 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Survey team: Janet Adams, RN Census bed type: SNF: 35 SNF/NF: 139 NCC: 6 Total: 180 Census payor type: Medicare: 40 Medicaid: 90 Other: 50 Total: 180 Sample: 6 This deficiency reflects state findings	F0000	St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	cited in accordance with 410 IAC 16.2. Quality review completed on August 22, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interview, the facility failed to ensure a bedside table was padded and a call light was in reach in order to accommodate the needs of 2 of 6 residents reviewed. (Residents #C and #D) Findings include: 1. On 8/17/12 at 1:00 p.m., Resident #C was observed in bed. The resident was awake. An over bed bedside table was pulled across the resident's lap. The resident's arms were over the table as the resident was eating her meal that was on the table. There was no padding on any sides of the table. There were no staff members or visitors in the room at this time. On 8/17/12 at 2:15 p.m. and 3:25 p.m., the resident was observed in bed. The resident was awake. The over bed bedside table was next to the resident's bed on her right side. The table was in the resident's reach. Items such as tissues and beverages were on top of the table.	F0246	Regarding Resident #C, the Unit Nurse Manager immediately assessed the resident and the resident's bedside table and noted the padding to be under the bed. The padding was re-secured to the bedside table at that time. Regarding Resident #D, the Unit Nurse Manager immediately placed the call light within the resident's reach. Unit Nurse Managers / designees immediately audited all residents who require padding to their bedside table to ensure compliance / padding in place with any deficiencies noted corrected at that time. Unit Nurse Managers / designees immediately audited resident rooms to ensure call lights were within reach with no other misplaced call lights noted. The Director of Staff Development / designee will inservice nursing staff regarding following the resident's plan of care and ensuring all interventions are in place including padding and proper call	09/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	There was no padding on any sides of the table. There were no staff members or visitors in the room at the above times. On 8/20/12 at 11:00 a.m., the resident was observed in bed. CNA #1 had just exited the resident's room. The resident's over bed bedside table was positioned next to the bed on the resident's right side . The table was in the resident's reach. There was no padding on the table. There were beverages and tissues on top of the table. The record for Resident #C was reviewed on 8/17/12 at 11:50 a.m. The resident's diagnoses included, but were not limited to, anxiety, depression, and dementia. Review of the 7/12 Physician orders indicated there was an order written on 7/20/12 to apply Steri Strips (thin adhesive strips to close wounds) to the skin tear on the resident's right elbow. Review of the 7/2012 Clinical Notes indicated an entry was made by nursing on 7/15/12 at 2:32 a.m. This entry indicated a 1.0 cm (centimeter) x 0.5 cm skin tear was noted to the resident's right elbow with a scant amount of blood present. The entry also indicated prior to the incident the resident was in bed with the bed side table on the right side and according to the CNA, the resident hit her		light placement. Unit Nurse Managers / designees will audit all residents per unit who require padded bedside tables daily and ensure intact. Audits will continue daily for a period of nine (9) months beginning the week of 9/9/12. Unit Nurse Managers / designees will audit at least five (5) resident call lights per unit per shift weekly to ensure proper placement. Audits will continue weekly for a period of nine (9) months beginning the week of 9/3/12. The DON / designee will report audit findings to the Quality Assurance (QA) Committee monthly for nine (9) months with the next meeting in September 2012. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. Completion date 9/19/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	right elbow on the bedside table. The entry also indicated a foam guard was to be applied to the bedside table. An "Incident Report Summary" was initiated on 7/20/12. The report summary indicated the resident was in bed and sustained a skin tear to her right elbow on 7/20/12. The skin tear measured 1.0 cm x 0.5 cm.. The investigative findings on the report summary indicated the resident's table was close to the bed because she liked to be able to reach for the things she kept on the bed side table. The action plan to be put into place was to pad the bedside table. A care card listing for Resident #C was reviewed on 8/20/12 at 8:00 a.m. The MDS (Minimum Data Set) Nurse provided the care card listing and identified it as the current one on the unit. An updated date of 8/17/12 was on the care card listing. Interventions to be in place for Resident #C included, padded upper 1/2 side rails and a pad to the bed side table. CNA #1 was interviewed on 8/20/12 at 11:01 a.m., upon exiting the resident's room. The CNA indicated the resident "bruises easy" and interventions that were to be in place for skin protection were padded bed rails. The CNA did not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	indicate the bed side table was to be padded. When interviewed on 8/20/12 at 11:10 a.m., the Unit Manager indicated the resident's bed side table should have been padded with foam as the resident had obtained a skin tear from hitting her elbow on the table. 2. On 8/17/12 at 11:10 a.m., Resident #D was observed sitting in a wheel chair in her room. There were no visitors or staff members in the room at this time. The resident's call light was on the the resident's bed. The call light was not in the resident's reach. There was gold star posted on the outside of the resident's room On 8/17/12 at 1:10 p.m., the resident was observed lying in bed. The resident's call light was under a folded blanket at the foot of the resident's bed. The call light was not in the resident's reach. There were no staff members or visitors in the resident's room. On 8/20/12 at 7:40 a.m., the resident was observed sitting in a wheel chair in her room. The resident's call light button was on the floor next to her wheel chair. The call light was not in the resident's reach. There were no staff members or visitors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/20/2012
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	in the room at this time. The record for Resident #D was reviewed on 8/17/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, osteoarthrosis, and a history of a left hip pinning. A 6/5/12 Fall Risk Screening Tool was completed on 6/5/12. The resident's total score was 14. The tool indicated a total score of 10 or higher represented a high risk for falls. When interviewed on 8/20/12 at 9:45 a.m., the Unit Manager indicated the resident's call light should have been in reach. The Unit Manager also indicated the resident was at risk for falls based on her diagnoses. The Unit Manager also indicated the gold star outside of the rooms indicated those residents were at risk for falls. This federal tag relates to Complaint IN00114043. 3.1-3(v)(1)			