

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  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  ST ANTHONY HOME - CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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F000000	<p>This visit was for the Investigation of Complaint IN00156004.</p> <p>Complaint IN00156004- Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226.</p> <p>Survey dates: September 16, 2014</p> <p>Facility number: 000120 Provider number: 155214 AIM number: 100274780</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF: 31 SNF/NF: 143 NCC: 1 Total: 175</p> <p>Census payor type: Medicare: 31 Medicaid: 95 Other: 49 Total: 175</p> <p>Sample: 5</p>	F000000	<p>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.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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F000223 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed on September 19, 2104, by Janelyn Kulik, RN.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were free from abuse from staff members, for 2 of 5 residents reviewed for abuse in a total sample of 5. (Residents # E, #F and Terminated CNA's #1 and #2)</p> <p>Findings include:</p>	F000223	1.1 Resident E was assessed by the charge nurse. Scratches were noted to resident E's right thigh. Licensed staff monitored area for complications with none noted. Upon notification to the DON and Administrator, the allegation of abuse was reported to the Indiana State Department of Health. The identified	10/03/2014

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	<p>1. Resident #E's record was reviewed on 09/16/14 at 10:15 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A Nurses' Note, dated 09/04/14 at 10:58 p.m., indicated it was a late entry for 09/13/14. The note indicated the CNA had reported several scratches to the resident's right inner thigh.</p> <p>An, "Investigative &amp; Reporting Form", dated 09/04/14, received from the Director of Nursing (DoN) on 09/16/14 at 9:55 a.m., indicated an incident occurred on 09/03/14 at 11 p.m. The form further indicated CNA #3 reported the resident became combative during care and held Terminated CNA #1's hand. CNA #3 reported Terminated CNA #1's reaction was to grab the resident's right thigh. The resident received four superficial scratches noted to his right inner thigh.</p> <p>The summary of the interview with CNA #3 indicated, "(CNA #3's name) was rendering care with (Terminated CNA #1's name) to this resident. During care this resident was combative &amp; began swinging at them. (CNA #3) then suggested to (Terminated CNA #1) that they return later &amp; let this resident calm down. (Terminated CNA #1) continued</p>		<p>associate was immediately placed on administrative leave. A thorough internal investigation was completed with appropriate action taken. 1.2 Other residents in this associate's care could potentially be affected by this individual. Identified associate was placed on administrative leave. Other residents in this associate's care that shift were assessed by Unit Manager with no other injuries of unknown origin noted and none voiced concern of abuse. Director of Staff Development (DSD) / designee will re-inservice staff on the types of abuse, timely notification to the Administrator and DON, how to recognize burnout in yourself and other associates, and when to report burnout to your supervisor. 1.3 The Director of Social Service / designee will conduct thirty (30) random staff interviews on all shifts weekly for four (4) months, then twice monthly for five (5) months for understanding of immediate notification of Administrator and DON and how to recognize burnout in yourself and other associates. Reinforcement of understanding will be immediately provided and documented to those who are unclear or unsure. 1.4 The Social Services Director / designee will report random staff interview findings to the Quality Assurance (QA) Committee monthly for nine (9) months. The</p>				

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	<p>to render care &amp; this resident grabbed (Terminated CNA #1) hand/arm. (CNA #3) then stated (Terminated CNA #1) reaction was to take hold of this resident's right thigh, squeeze, &amp; say, 'if you scratch me, I will scratch you.' "</p> <p>The interview with Terminated CNA #1 indicated she was rendering care with CNA #3 and the resident had grabbed her hand and squeezed it, and she was able to get her hand free. Terminated CNA #1 denied being upset with the resident and indicated she was unaware of the scratches on the resident's right leg. Terminated CNA #1 denied telling the resident she would scratch him and taking a hold of the resident's thigh.</p> <p>The conclusion indicated the allegation of abuse was substantiated and the CNA (Terminated CNA #1) was terminated from the facility and reported to the State agency.</p> <p>During an interview on 09/16/14 at 11:25 a.m., the DoN indicated she had interviewed other residents and there were no other complaints about Terminated CNA #1.</p> <p>2. Resident #F's record was reviewed on 09/16/14 at 1:15 p.m. The resident's diagnoses included, but were not limited</p>		<p>QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Correction date is October 3, 2014. 2.1 Resident F was observed by the Licensed Practical Nurse for any negative outcomes related to allegation of abuse. No negative outcome noted. Physician and family notified of same on date of allegation. Facility took immediate and appropriate action and reported this incident to the Indiana State Department of Health on 7/6/14. The identified associate was immediately placed on administrative leave. A thorough internal investigation was completed with appropriate action taken. 2.2 See 1.2 above. 2.3 See 1.3 above. 2.4 See 1.4 above. 2.5 See 1.5 above.</p>	

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	<p>to, dementia and heart disease.</p> <p>A progress note, dated 07/06/14 at 5:40 p.m., indicated the resident had an incident which occurred earlier in the day, which the resident was struck by a thrown fork on her left leg. The note further indicated Nursing immediately removed the CNA and followed the procedures. The note further indicated the ISDH (Indiana State Department of Health) and the local Police Department was notified.</p> <p>An, "Investigative &amp; Reporting Form", dated 07/06/14, and received from the DoN on 09/16/14 at 9:55 a.m., indicated the incident occurred on 07/06/14 at 1:30 p.m. The form indicated the resident was sitting in the dining room waiting for lunch and Terminated CNA #2 had taken the resident's clean fork and gave it to another resident and when Resident #F inquired about her fork, Terminated CNA #2 picked up the fork and threw it towards this resident hitting her left thigh. There was no injuries noted.</p> <p>Interviews with the witnesses (LPN #4, CNA #5, and NA #6) indicated Terminated CNA #2 gave the resident's fork to another resident and when Resident #F asked her why she took her fork, Terminated CNA #2 picked up</p>			

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	<p>another fork and threw it towards the resident, the fork hit the resident in the left leg then fell to the floor and Terminated CNA #2 told Resident #F to pick the fork up and use it.</p> <p>An interview with Terminated CNA #2 indicated when she handed the fork to Resident #F it dropped on the resident's tray. Terminated CNA #2 denied throwing the fork at the resident or saying anything negative to the resident.</p> <p>The conclusion of the investigation indicated the facility substantiated the abuse allegation.</p> <p>During an interview on 09/16/14 at 11:25 a.m., the DoN indicated (Terminated CNA #2) was placed on suspension, then terminated.</p> <p>This Federal Tag relates to complaint IN00156004.</p> <p>3.1-27(a)(1)</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225				10/03/2014	

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	<p>Based on record review and interview the facility failed to report an allegation of abuse timely to the Administrator of the facility, related to scratches on a resident's leg received during care, for 1 of 5 residents reviewed for abuse in a total sample of 5. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's record was reviewed on 09/16/14 at 10:15 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>An, "Investigative &amp; Reporting Form", dated 09/04/14, received from the Director of Nursing (DoN) on 09/16/14 at 9:55 a.m., indicated an incident occurred on 09/03/14 at 11 p.m. The form further indicated CNA #3 reported the resident became combative during care and held Terminated CNA #1's hand. CNA #3 reported Terminated CNA #1's reaction was to grab the resident's right thigh. The resident received four superficial scratches noted to his right inner thigh.</p> <p>The form indicated the Administration had not been notified of the allegation until 09/04/14 at 8:30 a.m. (9 1/2 hours later).</p> <p>During an interview on 09/16/14 at 11:25</p>		<p>1.1 Resident E was assessed by the charge nurse. Scratches were noted to resident E's right thigh. Licensed staff monitored area for complications with none noted. Upon notification to the DON and Administrator, the allegation of abuse was reported to the Indiana State Department of Health. The identified associate was immediately placed on administrative leave. A thorough internal investigation was completed with appropriate action taken.</p> <p>1.2 Other residents could potentially be affected by this practice; however, no other allegations occurred that day. Charge Nurse was immediately re-educated on immediate / timely notification of Administrator and DON when an allegation of abuse is initially reported. DSD / designee re-inserviced staff on immediate / timely notification to Administrator and DON when an allegation of abuse is initially reported.</p> <p>1.3 The Director of Social Service / designee will conduct thirty (30) random staff interviews on all shifts weekly for four (4) months, then twice monthly for five (5) months for understanding of immediate notification of Administrator and DON when an allegation of abuse is initially reported.</p>	

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F000226 SS=D	<p>a.m., the DoN indicated the allegation had not been reported until the following morning. When investigated, the Supervising Nurse indicated Terminated CNA #1 was at the end of her shift and had already left the building, so no other resident was at risk. She indicated the facility's policy had not been followed.</p> <p>This Federal Tag relates to complaint IN00156004.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to the resident's right to be free from abuse and</p>	F000226	<p>1.4 The Social Services Director / designee will report random staff interview findings to the Quality Assurance (QA) Committee monthly for nine (9) months. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance.</p> <p>1.5 Correction date is October 3, 2014.</p> <p>1.1 Resident E was assessed by the charge nurse. Scratches were noted to resident E's right thigh. Licensed staff monitored area for complications with none noted. Upon notification to the</p>	10/03/2014

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	<p>not immediately reporting an allegation of abuse to the Administrator of the facility, for 2 of 5 residents reviewed for abuse in a total sample of 5. (Residents #E and #F)</p> <p>Findings include:</p> <p>A facility policy, dated 10/01/94 and revised 09/14, received as current from the Administrator, and titled, "Alleged Abuse/Neglect/Mistreatment of a Resident/Misappropriation of Resident Property (Investigation of Same)", indicated, "...Any form of resident/patient abuse...of a resident...is strictly forbidden under all circumstances...Any associate who witnesses or becomes aware of an act of abuse...will immediately contact his/her Supervisor...who will in turn immediately notify the Facility Administrator or designee...Once report of patient/resident abuse...has been made, the Facility Administrator or designee shall be informed immediately within two (2) hours of occurrence...To ensure all residents/patients will be free from all forms of abuse and neglect..."</p> <p>1. Resident #E's record was reviewed on 09/16/14 at 10:15 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p>		<p>DON and Administrator, the allegation of abuse was reported to the Indiana State Department of Health. The identified associate was immediately placed on administrative leave. A thorough internal investigation was completed with appropriate action taken. 1.2 Other residents in this associate's care could potentially be affected by this individual. Identified associate was placed on administrative leave. Other residents in this associate's care that shift were assessed by Unit Manager with no other injuries of unknown origin noted and none voiced concern of abuse. Director of Staff Development (DSD) / designee will re-inservice staff on the types of abuse, timely notification to the Administrator and DON, how to recognize burnout in yourself and other associates, and when to report burnout to your supervisor. 1.3 The Director of Social Service / designee will conduct thirty (30) random staff interviews on all shifts weekly for four (4) months, then twice monthly for five (5) months for understanding of immediate notification of Administrator and DON and how to recognize burnout in yourself and other associates. Reinforcement of understanding will be immediately provided and documented to those who are unclear or unsure. 1.4 The Social Services Director /</p>				

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	<p>An, "Investigative &amp; Reporting Form", dated 09/04/14, received from the Director of Nursing (DoN) on 09/16/14 at 9:55 a.m., indicated an incident occurred on 09/03/14 at 11 p.m. The form further indicated CNA #3 reported the resident became combative during care and held Terminated CNA #1's hand. CNA #3 reported Terminated CNA #1's reaction was to grab the resident's right thigh. The resident received four superficial scratches noted to his right inner thigh.</p> <p>The form indicated the Administration had not been notified of the allegation until 09/04/14 at 8:30 a.m. (9 1/2 hours later).</p> <p>The summary of the interview with CNA #3 indicated, "(CNA #3's name) was rendering care with (Terminated CNA #1's name) to this resident. During care this resident was combative &amp; began swinging at them. (CNA #3) then suggested to (Terminated CNA #1) that they return later &amp; let this resident calm down. (Terminated CNA #1) continued to render care &amp; this resident grabbed (Terminated CNA #1) hand/arm. (CNA #3) then stated (Terminated CNA #1) reaction was to take hold of this resident's right thigh, squeeze, &amp; say, 'if you scratch me, I will scratch you.' "</p>		<p>designee will report random staff interview findings to the Quality Assurance (QA) Committee monthly for nine (9) months. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Correction date is October 3, 2014. 2.1 Resident F was observed by the Licensed Practical Nurse for any negative outcomes related to allegation of abuse; no negative outcomes were observed. Physician and family notified of same on date of allegation. Facility took immediate and appropriate action and reported this incident to the Indiana State Department of Health. The identified associate was immediately placed on administrative leave. A thorough internal investigation was completed with appropriate action taken. 2.2 Other residents in this associate's care could potentially be affected by this individual. Identified associate was placed on administrative leave. Other residents in this associate's care that shift were assessed by Unit Manager with no other injuries of unknown origin noted and none voiced concern of abuse. Director of Staff Development (DSD) / designee will re-inservice staff on the types of abuse, timely notification to the Administrator and DON, how to recognize burnout in yourself and other</p>	

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	<p>The interview with Terminated CNA #1 indicated she was rendering care with CNA #3 and the resident had grabbed her hand and squeezed it, and she was able to get her hand free. Terminated CNA #1 denied being upset with the resident and indicated she was unaware of the scratches on the resident's right leg. Terminated CNA #1 denied telling the resident she would scratch him and taking a hold of the resident's thigh.</p> <p>The conclusion indicated the allegation of abuse was substantiated and the CNA (Terminated CNA #1) was terminated from the facility and reported to the State agency.</p> <p>During an interview on 09/16/14 at 11:25 a.m., the DoN indicated the allegation had not been reported until the following morning. When investigated, the Supervising Nurse indicated Terminated CNA #1 was at the end of her shift and had already left the building, so no other resident was at risk. She indicated the facility's policy had not been followed.</p> <p>2. Resident #F's record was reviewed on 09/16/14 at 1:15 p.m. The resident's diagnoses included, but were not limited to, dementia and heart disease.</p> <p>A progress note, dated 07/06/14 at 5:40</p>		<p>associates, and when to report burnout to your supervisor. No other allegations occurred that day. Charge Nurse was immediately re-educated on immediate / timely notification of Administrator and DON when an allegation of abuse is initially reported. DSD / designee re-inserviced staff on immediate / timely notification to Administrator and DON when an allegation of abuse is initially reported. 2.3 The Director of Social Service / designee will conduct thirty (30) random staff interviews on all shifts weekly for four (4) months, then twice monthly for five (5) months for understanding of immediate notification of Administrator and DON and how to recognize burnout in yourself and other associates. Reinforcement of understanding will be immediately provided and documented to those who are unclear or unsure. The Director of Social Service / designee will conduct thirty (30) random staff interviews on all shifts weekly for four (4) months, then twice monthly for five (5) months for understanding of immediate notification of Administrator and DON when an allegation of abuse is initially reported. 2.4 The Social Services Director / designee will report random staff interview findings to the Quality Assurance (QA) Committee monthly for nine (9) months and. The QA Committee will monitor</p>				

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  09/16/2014	
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	<p>p.m., indicated the resident had an incident which occurred earlier in the day, which the resident was struck by a thrown fork on her left leg. The note further indicated Nursing immediately removed the CNA and followed the procedures. The note further indicated the ISDH (Indiana State Department of Health) and the local Police Department was notified.</p> <p>An, "Investigative &amp; Reporting Form", dated 07/06/14, and received from the DoN on 09/16/14 at 9:55 a.m., indicated the incident occurred on 07/06/14 at 1:30 p.m. The form indicated the resident was sitting in the dining room waiting for lunch and Terminated CNA #2 had taken the resident's clean fork and gave it to another resident and when Resident #F inquired about her fork, Terminated CNA #2 picked up the fork and threw it towards this resident hitting her left thigh. There was no injuries noted.</p> <p>Interviews with the witnesses (LPN #4, CNA #5, and NA #6) indicated Terminated CNA #2 gave the resident's fork to another resident and when Resident #F asked her why she took her fork, Terminated CNA #2 picked up another fork and threw it towards the resident, the fork hit the resident in the left leg then fell to the floor and</p>		<p>data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 2.5 Correction date is October 3, 2014.</p>				

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	<p>Terminated CNA #2 told Resident #F to pick the fork up and use it.</p> <p>An interview with Terminated CNA #2 indicated when she handed the fork to Resident #F it dropped on the resident's tray. Terminated CNA #2 denied throwing the fork at the resident or saying anything negative to the resident.</p> <p>The conclusion of the investigation indicated the facility substantiated the abuse allegation.</p> <p>This Federal Tag relates to complaint IN00156004</p> <p>3.1-28(a)</p>						