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	04/13/2023

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 Complaints IN00394994, IN00398551, IN00400567, IN00401416, and IN00405391. Complaint IN00394994 - No deficiencies related to the allegations are cited. Complaint IN00398551 - No deficiencies related to the allegations are cited. Complaint IN00400567 - No deficiencies related to the allegations are cited. Complaint IN00401416 - Federal/State deficiencies related to the allegations are cited at F684 and F697. Complaint IN00405391 - No deficiencies related to the allegations are cited. Survey date: April 13, 2023 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 148 SNF: 21 NF: 1 Total: 170 Census Payor Type: Medicare: 22 Medicaid: 116 Other: 32 Total: 170	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jami Moore	HFA	04/21/2023

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/14/23.			
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, record review and interview, the facility failed to ensure a resident received necessary treatment and services related to incorrect wound treatments and heel protectors not applied as ordered for 1 of 3 residents reviewed for wound treatment. (Resident C) Finding includes: On 4/13/23 at 10:27 a.m., RN 1 was observed changing the dressings to Resident C's feet. After removal of the old dressings, the RN washed the wounds on the right lateral foot and left toes with wound wash and a sterile gauze. She asked the resident if he was having any pain. The resident indicated his heels hurt. The nurse indicated he needed some heel cushions. She then applied bacitracin (antibiotic) ointment to the wound on the right foot and the left toes, applied a sterile gauze over the areas, and then wrapped both feet in Kerlix gauze. The resident's heels were not offloaded from the mattress with a pillow nor was	F 0684	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** The RN completed the treatment to the correct affected area per the Physician's order. Heel protectors were placed on this resident. Nurse management completed skin and pain assessment; no new concerns noted. Family and physicians were notified. No new orders received. This Resident is 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:** Whole house audit completed for	04/21/2023

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	he wearing heel protectors, which were lying on the floor in the room. The resident's record was reviewed on 4/13/23 at 9:25 a.m. The diagnoses included, but were not limited to, hemiparesis and hemiplegia following a stroke and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 1/27/23, indicated a moderate cognitive impairment, required extensive staff assistance for bed mobility, and was dependant on staff for transfers A Physician's Order, dated 3/16/23, indicated the right foot wound was to be cleansed with wound wash, patted dry, and calcium alginate was to be applied to the wound bed. The area was to be covered with a border dressing daily. A Physician's Order, dated 4/11/23, indicated the left toes were to be cleansed with wound wash, bacitracin ointment was to be applied and the areas were to be covered with a dry dressing daily. A Physician's Order, dated 1/23/23, indicated heel protectors were to be applied as tolerated every shift. An interview with RN 1, on 4/13/23 at 9:25 a.m., indicated she had provided the incorrect treatment to the right foot and would redo the treatment. She also indicated she was not aware the heel protectors were there, but was going to check his heels again. This Federal tag relates to Complaint IN00401416. 3.1-37		residents with orders of off-loading boots to ensure placement. Deficiencies were corrected at that time. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The Administrator re-educated the RN regarding following physician's orders as well as applying the correct treatment to the correct affected area. DON or designee re-educated licensed nursing staff on following physician orders as well as applying the correct treatment to the correct affected area. DON or designee also re-educated nursing staff on reviewing the resident's Treatment Administration Records (TAR) and/or care cards to ensure placement of offloading heels/boots. The Nurse Manager/designee will observe two (2) dressing changes per unit with Licensed Staff weekly to ensure the physician's order was followed as well as the correct treatment was applied to the correct affected area for six (6) months & the need for further monitoring to be determined by the QA committee. The Nurse Manager/designee will observe two (2) residents per unit weekly to ensure offloading heels/boots are in place for six (6) months & the need for further monitoring to be determined by	

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			the QA committee. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON or designee, with the oversight of the Administrator will monitor for compliance related to deficiencies for 6 months and the need for further monitoring to be determined by the QA committee. All results will be presented at QAPI for review and a plan implemented if trends are noted.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident's pain medication was administered as ordered for 1 of 3 residents reviewed for pain. (Resident C) Finding includes: Resident C's record was reviewed on 4/13/23 at 9:25 a.m. Diagnoses included, but were not limited to, hemiparesis and hemiplegia following a stroke and diabetes mellitus. The Quarterly Minimum Data Set assessment, dated 1/27/23, indicated the resident had moderate	F 0697	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident was assessed for pain, assessment WNL, no pain expressed. Family and physicians were notified. No new orders received. This Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the**	04/21/2023

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	cognitive impairment, required extensive staff assistance for bed mobility, was dependent on staff for transfers, and received scheduled and as needed pain medications. A Physician's Order, dated 12/16/22, indicated to give Norco (an opioid pain medication) 10/325 milligrams (mg) twice daily for chronic pain. A Physician's Order, dated 2/20/23, indicated to give Norco 10/325 mg every 24 hours as needed for breakthrough pain. A Physician's Order, dated 8/26/22, indicated to give Tylenol 650 mg every 4 hours as needed for mild pain. The February 2023 Medication Administration Record (MAR), indicated the resident had not received the scheduled dose of Norco on 2/6/23 in the morning and in the evening. The morning dose of the Norco had not been administered on 2/7/23. The March 2023 MAR indicated the resident had not received the scheduled Norco dose in the morning and evening on 3/3/23 and the morning dose of Norco had not been administered on 3/4/23. Electronic MAR notes,dated 2/6/23, indicated the Norco was not available. The notes dated 3/3/23 indicated the Norco had not been delivered by the Pharmacy. The note dated 3/4/23 indicated the Norco was on order. Interview with the Administrator, on 4/13/23, indicated she did not know why the Norco was not available and had no other additional information about the Norco.		**facility were identified to potentially be affected by the practice are:** Whole house audit completed of residents on pain medication to ensure availability as well as administration. Physician & Family notified of any deficiencies at that time. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Pharmacy reviewed EDK to ensure EDK supply/refill schedule is adequate for facility needs. Pharmacy to send weekly reports of residents needing scripts for pain medication refill. DON or designee re-educated licensed nursing staff/QMAS on medication administration, EDK procedures, pain management, and notification to physicians regarding unavailable pain medication. Nurse Manager/DNS will audit resident Medication Administration Records (MARS) requiring pain medication to ensure administered per order 5 times a week for 3 months; then weekly for 3 months, & the need for further monitoring to be determined by the QA committee. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:**	

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	This Federal tag relates to Complaint IN00401416. 3.1-37(a)		DON or designee, with the oversight of the Administrator will monitor for compliance related to deficiencies daily for 3 months; then weekly for 3 months, and the need for further monitoring to be determined by the QA committee. All results will be presented at QAPI for review and a plan implemented if trends are noted	