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	06/16/2023

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00408169, IN00408785, IN00409587 and IN00410203. Complaint IN00408169 - Federal/State deficiencies related to the allegations are cited at F695. Complaint IN00408785 - Federal/State deficiencies related to the allegations are cited at F690 and F725. Complaint IN00409587 - No deficiencies related to the allegations are cited. Complaint IN00410203 - Federal/State deficiencies related to the allegations are cited at F554, F585, F677 and F725. Survey dates: June 12, 13, 14, 15 and 16, 2023. Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 149 SNF: 20 NCC: 2 Total: 171 Census Payor Type: Medicare: 19 Medicaid: 117 Other: 35 Total: 171	F 0000		

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/21/23.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside for 2 of 2 random observations. (Residents H and F) Findings include: 1. On 6/12/23 at 11:33 a.m., Resident H was observed lying in her bed. There was a Symbicort inhaler on her bedside table. On 6/12/23 at 2:56 p.m., the inhaler was observed still on her bedside table The record for Resident H was reviewed on 6/15/23 at 9:09 a.m. Diagnoses included, but were not limited to cellulitis, dementia and neoplasm of the brain. The Admission Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident had moderate cognitive deficits and required a total of 2 staff assistance for bed mobility and transfers. A Physician's Order, dated 5/20/23, indicated to give Symbicort Inhalation 2 puffs, twice daily.	F 0554	**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Self-administration assessments were completed for residents observed in this deficiency. Family and physicians were notified. Physicians gave new orders for residents to keep medications at bedside/self-administer medications. Residents are 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:** Facility to interview cognitive residents to identify any residents who wish to keep medications at bed side or self-administer medications. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:**	07/07/2023

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	There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, Lumigan 0.01% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication assessment evaluation, a Physician's Order to self-administer mediations, or a care plan to self-administer medications had been completed.		Family and residents were educated to notify clinical leadership if resident wishes to keep medications at bed side or has desire to self-administer medications. IDT will discuss self-administration with families and residents during care plan meetings. Nursing staff educated on self-administration policy for residents and completing self-administration resident assessments if appropriate. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/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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	Physician Orders, dated 2/3/23, indicated the following: - Lantanoprost Solution 0.005%, instill 1 drop in the left eye at bedtime. - Timolol Maleate Gel Forming Solution 0.5 %, instill 1 drop in the left eye two times a day. - Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate), instill 1 drop in the left eye every 12 hours. - Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophth), instill 1 drop in both eyes every 6 hours as needed. Interview with LPN 1 on 6/14/23 at 11:50 a.m., indicated she administered eye drops for resident F that come from her medication cart. She did not administer any medication that the resident had at his bedside. Interview with the Director of Nursing (DON) on 6/15/23 at 1:13 p.m., indicated they did not have a self medication assessment evaluation form on file for this resident. This Federal tag relates to Complaint IN00410203. 3.1-7(a)(2)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as			

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	well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;			

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	(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed			

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	by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on record review, and interview, the facility failed to report, investigate the root cause, and resolve resident grievances for 2 of 2 residents reviewed for grievances. (Residents D and J) Findings include: 1. The record for Resident D was reviewed on 6/14/22 at 2:54 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, dementia with behavioral disturbance, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 4/21/23, indicated the resident was mildly cognitively impaired and required extensive assist x 1 for personal hygiene and bathing. A Grievance form, dated 5/2/23, indicated the resident had not received her shower on 5/1/23. The findings indicated the resident's family had her shower day mixed up and the resident was given a shower on 5/3/23. A Grievance form, dated 5/3/23, indicated the resident's showers were not given consistently per the resident's daughter. The findings indicted the resident had not received her shower on the scheduled day and the shower was provided on	F 0585	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Grievances for identified residents were completed resolved. Family and physicians were notified. Physicians gave no new orders. Residents are 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 the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Facility staff educated on grievance procedures and policies related to reporting requirements. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:**	07/07/2023

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	the following day shift. A Grievance form, dated 5/26/23, indicated the resident's family voiced ongoing concerns with the resident not receiving showers. The family asked if they could assist the resident with showering when they visited. The findings indicated the resident had been given a shower on 5/25/23. A Grievance form, dated 6/6/23, indicated the resident had again not received a shower in over a week per her daughter. She was also requesting follow up on directions so she could assist the resident with a shower when visiting. The findings indicated a shower was provided by staff and family was provided follow up for future showers. Interview with the Executive Director and the Administrator on 6/15/23 at 10:15 a.m., indicated they had been staffing challenged on second shift and getting scheduled showers done on that shift had been an issue. The grievances had the same repeated concern. They offered to switch the resident's showers to day shift but the family wanted to keep them on second shift so they could assist at times when they were visiting. Some showers had been missed and they had been completed the following day shift.2. On 6/12/23 at 10:11 a.m., a locked wheelchair was observed blocking the entrance into Resident J's room. The resident indicated the wheelchair was in place related to another resident wandering in her room at night and stealing her snacks. The record for Resident J was reviewed on 6/14/23 at 8:45 a.m. Diagnoses included, but were not limited to, anemia (low iron), depression, type 2 diabetes, heart failure, and hypertension (high		SSD/designee will conduct audit (1) times a week for (6) months to identify any grievance trends. Any trends will be reported to Executive Director and Administrator. SSD/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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	blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 5/1/23, indicated the resident was cognitively intact. Interview with CNA 3 on 6/13/23 at 3:01 p.m., indicated another resident had wandered into Resident J's room and took the resident's snacks. The resident had asked for the wheelchair to block her door. Interview with LPN 1 on 6/14/23 at 9:37 a.m., indicated she had no issues getting into the resident's room and if there were an emergency, she could remove the chair in seconds. The wheelchair was placed there due to someone going in her room and removing her snacks. Interview with the Director of Nursing (DON), on 6/14/23 at 9:41 a.m., indicated she was unaware a wheelchair was placed in front of the resident's door or her allegation of snacks being taken, as nothing was reported by floor staff. She would speak to the resident and place a stop sign intervention instead to see if that worked. The DON removed the locked wheelchair, indicating the resident was not completely bedbound and does get up sometimes. A grievance, dated 6/14/23, indicated the resident's concern related to a co-resident entering her room and taking her "snacks". The grievance was signed by Social Services on 6/14/23. Interview with the Administrator on 6/15/23 at 11:30 a.m., indicated she was unaware a resident had complained to staff that someone wandered into her room and stole her snacks until the day			

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	before. The staff should have notified her right away so a grievance could have been completed instead of just putting a wheelchair in her doorway to prevent anyone from wandering into her room. A facility policy titled, "Resident Concerns and Grievances" and received as current, indicated, "... A concern/grievance of any kind is documented on a Report of Concern Form ... The Executive Director/Grievance Official is responsible for overseeing the grievance process and will collaborate with state and federal agencies, as necessary. The Executive Director/Grievance Official will report allegations of neglect, abuse, and/or misappropriation of resident property, by anyone providing services on behalf of the facility as required by the regulations and law of the state by which the facility is located ..." This Federal tag relates to Complaint IN00410203. 3.1-11(a)			
F 0677 SS=D 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 record review and interview, the facility failed to ensure showers were provided as scheduled for a dependent resident for 1 of 11 residents reviewed for activities of daily living (ADL) care. (Resident L) Finding includes: On 6/12/23 at 1:01 p.m., Resident L indicated he	F 0677	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident grievance was completed. Shower was provided. Resident interview complete for resident showering preferences. Family and physicians were	07/07/2023

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	wasn't getting his scheduled showers, he hadn't been showered in over a week. The resident's record was reviewed on 6/14/23 at 12:14 p.m. Diagnoses included, but were not limited to, Muscular Sclerosis and Diabetes Mellitus. The Annual Minimum Data Set assessment, dated 5/4/23, indicated the resident was cognitively intact, and required extensive assistance of 2 for bed mobility and transfers. The shower schedule indicated the resident was to be showered on Wednesday and Saturday evenings. Shower sheets for the past 30 days indicated the resident had a bed bath on 5/6/23. The Point of Care charting (used by CNAs) indicated the resident got a shower on 5/25/23 and 6/7/23. There was no additional documentation. Interview with CNA 1 on 6/14/23 at 2:25 p.m., indicated she was the only CNA on the hall that day. She was able to give 1 of the 4 scheduled showers. She indicated it was impossible to give all the showers when working alone. Interview with the Administrator and Executive Director on 6/15/23 at 10:14 a.m., indicated they would look into it. There was no additional information provided. This Federal tag relates to Complaint IN00410203. 3.1-38(a)(3)		notified. Physicians gave no new orders. Residents are 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 the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Facility clinical staff were educated on providing showers to resident. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit (5) residents per unit (5) times a week for (6) months to ensure showers are provided a scheduled. 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.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	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 skin discolorations were assessed and monitored, a treatment order for a bandage was in place, and a treatment was in place for dry and flaky legs for 3 of 7 residents reviewed for non-pressure skin conditions. (Residents H, 5 and D) Findings include: 1. On 6/12/23 at 11:33 a.m., Resident H was observed lying in her bed. There was a dark purplish discoloration on her left forearm and left thigh. The resident indicated she did not know what happened to the areas. On 6/13/23 at 10:09 a.m., the resident was again observed in bed and the discoloration to her left forearm and left thigh were visible. The record for Resident H was reviewed on 6/15/23 at 9:09 a.m. Diagnoses included, but were not limited to cellulitis, dementia and neoplasm of the brain. The Admission Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident had moderate cognitive deficits and required total 2 staff assistance for bed mobility and transfers. A Medication Care Plan indicated the resident was at increased risk of bruising and bleeding	F 0684	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Residents were assessed and monitoring put in place for bruising. MD was notified of treatment placed on resident 5, new orders received. Resident D received lotion for her dry flaky skin on lower extremity. Family and physicians were notified. Residents are 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 the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on obtaining orders for any treatment placed on residents, monitoring bruises, and ensure orders to be obtained for dry flaky skin. **Quality Assurance plans and**	07/07/2023

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	related to antiplatelet and aspirin use. Interventions included to observe for abnormal signs of bleeding such as increased frequency of bruising and increased size of bruising. Document findings and notify the Physician. There was no documentation or monitoring of the discolorations in the resident's record. On 6/15/23 at 10:20 a.m., the Executive Director was made aware there was no documentation or monitoring of the discolorations. There was no additional information provided. 2. On 6/12/23 at 2:14 p.m., Resident 5 was observed lying in bed. The resident had multiple purple discolorations to both arms. The resident also had a bandage to his right elbow. The bandage was not dated or initialed for when it was applied. The resident indicated his elbow was cut on the strap from the transfer lift and the nurse had applied the bandage. On 6/14/23 at 9:20 a.m., Resident 4 was observed lying in bed. There were multiple purple discolorations observed to both his arms as well as the undated bandage to his right elbow. Record review for Resident 5 was completed on 6/15/23 at 9:24 a.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was moderately cognitively impaired. The resident required an extensive 2+ person assist for bed mobility, transfers, toilet use, and personal hygiene. The resident had received an anticoagulant (prevent blood clots) medication.		**monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit (5) residents per unit (5) times a week for (6) months to identify any new non-pressure skin concerns are monitored and addressed. Any trends will be reported to Executive Director and Administrator. 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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	155214	A. BUILDING 00 B. WING	06/16/2023

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	A Care Plan, dated 8/30/21, indicated the resident was at risk for abnormal bleeding secondary to anticoagulant therapy for atrial fibrillation. An intervention included to inspect the skin during care for bruising or increased bruising and to notify the nurse of abnormal findings. The June 2023 Physician's Order Summary (POS) indicated an order for Eliquis (anticoagulant) 2.5 mg (milligrams) twice a day for atrial fibrillation. There was no documentation to indicate the discolorations had been assessed or monitored. There was no documentation to indicate why the bandage was on the resident's elbow or any treatment orders in place for the bandage. Interview with the Director of Nursing (DON) on 6/15/23 at 12:58 p.m., indicated the wound nurse was unaware of the resident's bandage on his elbow. She couldn't provide any documentation related to the assessment, monitoring, or treatment orders for the discolorations or the bandage. 3. Interview with Resident D on 6/12/23 at 9:55 a.m., indicated her legs and feet had dry skin. Staff had not put any lotion on her legs. She was observed with dry flaky skin to both legs and ankles and she had a small dry scabbed area on her left shin. On 6/14/23 at 11:13 a.m., the resident was observed seated in her wheelchair in her room. Dry flaky skin was observed to both lower extremities. The record for Resident D was reviewed on 6/14/22 at 2:54 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, dementia with behavioral disturbance, and major depressive disorder.			

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	The Quarterly Minimum Data Set (MDS) assessment, dated 4/21/23, indicated the resident was mildly cognitively impaired and required extensive assist of 1 staff for personal hygiene and bathing. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 6/2023, indicated the resident received Lasix (a diuretic medication) 40 mg (milligrams) twice daily. There was lack of any treatment for the dry flaky skin to the resident's lower extremities. The Weekly Nursing Summary, dated 6/12/23, indicated the resident's skin was warm and dry and there were no current concerns. Interview with the DON on 6/15/23 at 12:41 p.m., indicated the resident's legs were dry and she would obtain orders for lotion. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review and interview, the facility failed to ensure a resident's positioning was maintained related to a hand splint not applied as ordered for 1 of 2 residents reviewed for positioning/ mobility. (Resident 74) Finding includes: On 6/12/23 at 10:12 a.m., Resident 74 was observed in bed, there was no hand splint on her right hand. She was again observed in her room on 6/12/23 at 11:16 a.m., 6/14/23 at 9:25 a.m., 6/15/23 at 8:50 a.m., and 11:12 a.m., 6/16/23 at 9:41 a.m. and 10:21 a.m., with no hand splint on her right hand. The resident's record was reviewed on 6/16/23 at 10:08 a.m. Diagnoses included, but were not limited to, chronic pain syndrome and hypertension. A Quarterly Minimum Data Set assessment, dated 4/4/23, indicated the resident was cognitively intact and required extensive assistance of two staff for bed mobility and transfers. A Physician's Order, dated 1/13/23, indicated to wear a splint to the right hand at all times, to be removed for skin checks each shift. The June 2023 Medication Administration Record indicated the right hand splint was applied every shift, every day in June.	F 0688	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident 74 was assessed. Splint was placed on residents per MD order. Family and physicians were notified. Physician gave no new orders. 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 of residents with splint orders was complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring splints are worn by residents per MD order. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit residents with splints (5) times a week each unit for (6) months to	07/07/2023

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	There was no documentation to indicate the resident refused or removed the splint. Interview with the resident on 6/16/23 at 10:21 a.m., indicated sometimes the staff would put the splint on and sometimes they wouldn't. She indicated she did not know where the splint was currently. Interview with Executive Director on 6/16/23 at 11:40 a.m., indicated the resident would sometimes remove the splint and she would look into the concern. There was no additional information provided. 3.1-42(a)(2)		ensure splits are in place per MD order. Any trends will be reported to Executive Director and Administrator. 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.	
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 observation, record review, and interview, the facility failed to provide supervision and follow protocols related to random observations of residents transferred by a Hoyer lift (suspension lift to reposition and transfer into a chair or bed) for 2 of 2 Hoyer transfers observed. (Residents B and 151) Findings include: 1. During a random observation on 6/14/23 at 9:30	F 0689	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Residents were assessed. Family and physicians were notified. Physician gave no new orders. Resident is in stable condition and experienced no negative outcomes as a result of this observation.	07/07/2023

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	a.m., CNA 2 was observed in Resident's B's room to transfer him from his bed to his wheelchair via a Hoyer lift. CNA 2 was the only staff member in the room completing the transfer. On 6/14/23 at 9:42 a.m., CNA 2 left the resident's room and the resident was sitting in his wheelchair. Record review for Resident B was completed on 6/13/23 at 2:00 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, end stage renal disease, and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 4/17/23, indicated the resident was cognitively impaired. The resident required a total 2+ person assist for transfers. The resident had an impairment on one side of his upper and lower extremities for a functional limitation in range of motion. A Care Plan, dated 4/21/23, indicated the resident needed assistance with activities of daily living. An intervention included the resident required a total assistance of 2 staff for transfers. 2. During a random observation on 6/14/23 at 9:54 a.m., CNA 2 was observed getting Resident 151 out of bed via a Hoyer lift. CNA 2 was the only staff member in the room completing the transfer. On 6/14/23 at 9:59 a.m., CNA 2 left Resident 151's room. The resident was sitting in his wheelchair. Record Review for Resident 151 was completed on 6/14/23 at 9:50 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia, and dementia. The Annual MDS assessment, dated 5/12/23,		**How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of residents requiring Hoyer lift complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on following mechanical lift protocols for safe transfers. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct random observation of hoyer transfers of (5) residents per unit (5) times a week for (6) months. 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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	indicated the resident was cognitively impaired. The resident required an extensive 2+ assist for transfers. The resident had an impairment on one side of his upper and lower extremities for functional limitation in range of motion. A Care Plan, dated 4/6/23 and revised 5/15/23, indicated the resident needed assistance with activities of daily living. An intervention included the resident required an extensive 2 staff assistance with transfers. Interview with CNA 2 on 6/14/23 at 9:59 a.m., indicated she had gotten both Resident B and Resident 151 out of bed and into their wheelchairs by herself via the Hoyer lift. There were 2 aides and 1 nurse working the hall that day. She indicated normally there was only 1 aide that worked the hall, so she was use to getting residents up by herself. She didn't ask the other aide or the nurse for help. Interview with the DON (Director of Nursing) on 6/14/23 at 10:07 a.m., indicated the staff are supposed to use 2 staff members when they transfer residents via a Hoyer lift. The CNA should have asked for assistance before transferring the residents by herself with the Hoyer lift. A policy titled, "Safe Resident Handling/Transfer" and received as current from the facility on 6/14/23, indicated, "...10. Two staff members must be utilized when transferring residents with a mechanical lift..." 3.1-45(a)(2)			
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI			

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Bldg. 00	§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary tract infection (UTI) received the necessary treatment and services related to completing an ordered laboratory test timely for 1	F 0690	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident UA was complete.	07/07/2023

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	of 2 residents reviewed for urinary tract infections. (Resident K) Finding includes: On 6/12/23 from 2:23 p.m. through 2:36 p.m., Resident K was observed lying in her bed. The resident was repetitively yelling out "I need help. Where am I going to go? Somebody help me. Where will I go?" The Unit Manager entered the room and spoke to the resident. Upon exiting the room, the resident again began repetitively yelling out. The record for Resident K was reviewed on 6/16/23 at 9:21 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, hypertension, and atrial fibrillation. A Psych Services Progress Note, dated 6/1/23, indicated the resident was experiencing worsening behaviors and anxiety. A medication change was made, and a urinalysis (UA, urine test) was ordered. A Progress Note, dated 6/2/23, indicated the urine sample was obtained and placed in the refrigerator for pick up. A Progress Note, dated 6/3/23, indicated the urine sample was available for lab pickup. A Progress Note, dated 6/5/23 at 1:32 p.m., indicated the urine sample that was collected on 6/2/23 had not been picked up by the lab until 6/5/23. The lab was unable to use the specimen because it was too old. A Progress Note, dated 6/5/23 at 2:22 p.m., indicated a new urine sample was obtained and		Facility obtained orders for treatment for UTI. Family and physicians were notified. 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:** All residents have potential to be effective by this deficiency. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring laboratory test are completed timely. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit daily (5) times a week for (6) months to identify any pending laboratory tests to ensure timely completion. 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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	placed in the refrigerator for pick up. A Progress Note, dated 6/6/23 at 2:17 p.m., indicated the UA results had been received and sent to the Physician. A urine culture, dated 6/6/23, indicated the urine was positive for > (greater than) 100,000 Escherichia coli and >100,000 proteus mirabilis (bacteria). A Nurse Practitioner Note, dated 6/9/23, indicated she had seen the resident today for an abnormal urinalysis. The urine culture was positive for E. coli (Escherichia coli, a bacteria), the resident was diagnosed with a UTI and started on Macrobid (an antibiotic) 100 mg (milligrams) twice a day for 7 days. Interview with the Director of Nursing (DON) on 6/16/23 at 11:33 a.m., indicated the UA had been ordered for a Friday, 6/2/23. Lab services did not regularly pick up on weekends, so the sample wasn't picked up until Monday 6/5/23. By then, the sample was too old and a new sample was collected the same day. No antibiotics were started until 6/9/23 because the Physician was waiting for the urine culture to be complete. She indicated she would need to come up with a better process for labs that were ordered on the weekend. This Federal tag relates to Complaint IN00408785. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to provide proper respiratory care and services related to not changing nebulizer (machine that turns liquid medications into a mist to be inhaled) masks timely and not completing nebulizer treatment assessments as ordered for 1 of 3 residents reviewed for oxygen. (Resident B) Finding includes: On 6/12/23 at 10:33 a.m., a nebulizer mask was observed in a bag laying on Resident B's bed. The mask was dated 5/27. On 6/13/23 at 10:24 a.m., Resident B was observed lying in bed. A nebulizer mask was in a bag on the resident's wheelchair. The mask was dated 5/27. Record review for Resident B was completed on 6/13/23 at 2:00 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, end stage renal disease, and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 4/17/23, indicated the resident was cognitively impaired. The resident had received oxygen therapy. A Care Plan, dated 4/21/23, indicated the resident	F 0695	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident was assessed. Assessment and vitals were both within normal limits. Family and physicians were notified. Physician gave no new orders. 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 of residents who receive nebulizer treatments. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring nebulizer treatments are complete pr MD orders, masks are changed within policy guidelines, and vitals are taken per MD order. **Quality Assurance plans and monitoring practices that have been implemented to make**	07/07/2023

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	was at risk for respiratory distress related to respiratory failure. An intervention included for vital signs and oxygen saturation as ordered and as indicated. The June 2023 Physician's Order Summary (POS) indicated orders for the following: - albuterol sulfate (used to prevent and treat wheezing and shortness of breath caused by breathing problems) inhalation nebulizer solution; 3 ml (milliliters) inhaled via nebulizer two times a day - document the pulse, respiratory rate, breath sounds, oxygen saturation and minutes before and after nebulizer treatments - change nebulizer tubing weekly The June 2023 Medication Administration Record (MAR) had the order to document the pulse, respiratory rate, breath sounds, oxygen saturation and minutes before the nebulizer treatments. The MAR had check marks it was completed but there was no documentation of the vital sign results. Interview with the Director of Nursing (DON) on 6/13/23 at 2:10 p.m., indicated the nebulizer masks were supposed to be changed weekly. Interview with the DON on 6/15/23 at 12:58 p.m., indicated the nebulizer assessment order was not put in correctly. The MAR should have had values for the vital signs instead of only check marks when it was completed. This Federal tag relates to Complaint IN00408169. 3.1-47(a)(6)		**sure corrections are achieved and are permanent are:** DON/designee will conduct audit (5) residents per unit if applicable (5) times a week for (6) months to ensure nebulizer equipment is changed per policy, nebulizer treatments are complete, and vitals are taken per MD order as it related to nebulizer treatments. 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.	
F 0725 SS=E	483.35(a)(1)(2) Sufficient Nursing Staff			

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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
Bldg. 00	§483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review and interview, the facility failed to ensure there was adequate nursing staff available to meet the residents' needs related to receiving scheduled showers for 1 of 9 units reviewed for staffing. (Unit 3A) Finding includes: On 6/14/23, the 3A unit was observed continuously from 10:15 to 11:40 a.m. The was one QMA and one CNA on the unit. There were 24	F 0725	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident received shower. Family and physicians were notified. Physician gave no new orders. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the**	07/07/2023

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	155214	A. BUILDING 00 B. WING	06/16/2023

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	residents on the unit. There was no additional staff on the unit. The shower book indicated there were four residents scheduled to receive a shower that day on day shift. Interview with QMA 1 on 6/14/23 at 2:00 p.m., indicated there was only one CNA that day. There were sometimes two CNAs, or a split that would work two units. She indicated they would offer residents bed baths instead of showers when they were short staffed. Interview with CNA 1 on 5/14/23 at 2:25 p.m., indicated she was only able to give one of the four scheduled residents a shower that day. When working alone it was impossible to give all four showers during a shift. Interview with the Executive Director and the Administrator on 6/15/23 at 10:14 a.m., indicated when there was a call off or staffing shortage, the clinical supervisors should assist. They would look into the staffing on 3A the previous day. There was no additional information provided. This Federal tag relates to Complaints IN00408785 and IN00410203. 3.1-17(b)		**facility were identified to potentially be affected by the practice are:** Whole house audit of residents who resides on unit to ensure shower was complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Clinical leadership educated on ensuring units have assistance to provide showers as scheduled. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit (5) residents per unit (5) times a week for (6) months to ensure showers are complete. Any trends will be reported to Executive Director and Administrator. 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. It is stated in the citation, "Interview with C.N.A. 1 on 6/14/23 at 2:25 p.m indicated she was only able to give one of the four scheduled residents a shower that day. When working alone it was impossible to give all four showers	

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			during a shift." This interview does not indicate if C.N.A. had requested additional assistance from the clinical leadership on the date in question or if clinical leadership had addressed care needs. Furthermore, it was stated in the citation, "Interview with the Executive Director and the Administrator on 6/15/23 at 10:14 a.m. indicated when there was a call off or staffing shortage, the clinical supervisors should assist. They would look into the staffing on 3A the previous day." This interview indicates that if there is a need for additional support on the floor, clinical leadership responds to ensure adequate nursing staff. The facility would like to provide documentation indicating that an additional 68.03 hours of clinical leadership worked for the date in question (attachment 1). As the detailed hours report indicates there was sufficient nursing staff within the facility to provide the care needed. The following is a breakdown of the hours for date citied 6/14/23 supporting clinical leadership within the facility at the time of citation (attachment 2 provides copies of licensure of each individual to support appropriate nursing competencies and skills). These individuals were not assigned to specific units, however, were available if a unit needed assistance providing adequate care. In addition, the	

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			report will indicate all clinical staff on shift, who were assigned to units for the complete 24 hours on 6/14/2023. The following clinical leadership was within the facility within the time frame citied, and able to provide care where needed: • Courtney Grupka, Central Supply Director, Certified Nursing Aide., hours worked 8.67 • Falon Wendel, Director of Nursing, Registered Nurse, hours worked 9.00 • Cheryl Young, Infection Control Staff Developer, Licensed Professional Nurse, hours worked 9.00 • Alice Finney, MDS Coordinator Assistant, Registered Nurse, hours worked 10.38 • Katherine Geffert, Staff Scheduler, Qualified Medication Aide, hours worked 11.83 • Michelle Luedtke, Unit Manager, Licensed Professional Nurse, hours worked 10.75 • Cassie Travis, MDS Coordinator Assistant, Licensed Professional Nurse, hours worked 8.40 In conclusion, although the C.N.A. indicated that she did not provide the showers, the facility did have adequate staffing to assist with the showers, if requested or noted needing assistance. The regulations states, “The facility must have sufficient nursing staff with the appropriate competencies an skills sets to provide nursing	

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			and related services to assure resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident…" The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s):483.35(a)(1)(2); scope and severity level E, be removed from survey.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, record review, and interview, the facility failed to ensure residents were free from unnecessary psychoactive medications related to administration of an anti-anxiety medication as ordered and antipsychotic medication use for 1 of 5 residents reviewed for unnecessary medications and 1 of 2 residents reviewed for behavior/ emotional care. (Residents D and K) Findings include:	F 0758	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Psych and MD were notified of resident D's lack of documentation for Abilify usage. Psych and MD were notified of delayed medication. Resident was assessed. Family and physicians were	07/07/2023

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	1. The record for Resident D was reviewed on 6/14/22 at 2:54 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, dementia with behavioral disturbance, and major depressive disorder. The resident was admitted to the facility on 1/12/23. The Quarterly MDS (Minimum Data Set) assessment, dated 4/21/23, indicated the resident had not had any behaviors. She received antipsychotic and antidepressant medications. A Progress Note, dated 1/20/23, indicated the resident's family was requesting she be started on Abilify (aripiprazole, an antipsychotic medication) as she would have hallucinations without the medication. The Physician was notified of the family's request. A Psych Services Progress Note, dated 1/23/23, indicated there was no reported new or worsening psychiatric behaviors, no reports of delusions, hallucinations, or paranoia. They spoke with the resident's daughter regarding the resident's medications. She indicated the resident had received medication for hallucinations where she had previously resided, and they had discontinued her Abilify abruptly without tapering. Psych Services explained they would prescribe a different medication for the hallucinations. The resident's daughter was in agreement and Nuplazid (an antipsychotic medication) 34 mg (milligrams) daily was ordered. An IDT (interdisciplinary team) Note, dated 1/25/23, indicated the Physician in house would review the resident. The resident was started on a new medication and the Physician and family were in agreement with the plan of care.		notified. Physician gave new order for GDR of Abilify for resident D and no new order for resident K. Residents are 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 on psychotic medications 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:** Nursing staff educated on follow-up with MD and pharmacy of unavailable medications. Nursing staff and MD educated on ensuring residents have supporting documentation for prescribed psychotropic medications. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** SSD/designee will conduct audit daily (5) times a week for (6) months to identify any new prescribed psychotropic medications and ensure there is supporting documentation for medication. DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The	

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	A Physician's Order, dated 1/25/23, indicated an order for Abilify 10 mg at bedtime. The 6/2023 Medication Administration Record (MAR), indicated the resident had received the Abilify medication as ordered. A Psych Services Progress Note, dated 6/8/23, indicated the Abilify had previously been reduced and discontinued at a previous facility. The medication had been resumed by the POA (power of attorney, responsible party) and the PCP (primary care provider). There was lack of any documented hallucinations or behaviors for January 2023. There was lack of documentation from the Physician of the clinical reasoning as to why the Abilify had been started on 1/25/23. Interview with the Director of Nursing (DON) on 6/15/23 at 1:48 p.m., indicated the resident's family had indicated the resident was on Abilify for years at her previous facility and then it was abruptly discontinued. They requested the Physician restart it and he had. She was unable to provide any further documentation of any behaviors, or any progress note from the Physician. 2. On 6/12/23 from 2:23 p.m. through 2:36 p.m., Resident K was observed lying in her bed. The resident was repetitively yelling out "I need help. Where am I going to go? Somebody help me. Where will I go?" The Unit Manager entered the room and spoke to the resident. Upon exiting the room, the resident again began repetitively yelling out. The record for Resident K was reviewed on		QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	6/16/23 at 9:21 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, hypertension, and atrial fibrillation. A Psych Services Progress Note, dated 6/1/23, indicated the resident was experiencing worsening behaviors and anxiety. Xanax (an anti-anxiety medication) 0.25 milligrams (mg) twice daily was discontinued and clonazepam (an anti-anxiety medication) 0.25 mg twice a day for 14 days was started. A Physician's Order, dated 6/1/23, indicated clonazepam 0.25 mg twice daily for 14 days. The MAR, dated 6/2023, indicated the resident had not received the clonazepam medication as ordered on the following dates and times: - 6/2/23 6:00 a.m. - 6/3/23 6:00 a.m. "Dosage different than entry. Clarification needed from pharmacy." - 6/3/23 6:00 p.m. "Awaiting med (medication) from pharmacy." - 6/4/23 6:00 a.m. - 6/4/23 6:00 p.m. "Med (medication) not available." - 6/5/23 6:00 p.m. "Medicine did not arrive from pharmacy." - 6/6/23 6:00 a.m. A Psych Services Progress Note, dated 6/8/23, indicated "...Spoke with nursing staff regarding behaviors since medication change. Reported the new medication was started late due to issues with delivery from the pharmacy. Therefore, the resident has been having the same yelling and screaming episodes..." Interview with the DON on 6/16/23 at 11:33 a.m., indicated the resident had not received the			

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	clonazepam as ordered. She was unsure why the medication had not arrived from the pharmacy timely. 3.1-48(a)(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were labeled correctly related to eye drops, nasal sprays, and insulin with no labels and insulin in use that was expired for 3 of 5 medication carts	F 0761	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Medications were removed from	07/07/2023

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	observed. (3D, 2D, and 1A Medication Carts) Findings include: 1. On 6/14/23 at 10:26 a.m., the 3D Medication Cart was observed with QMA 3. Resident 149's insulin glargine 100 unit/milliter (mL) vial was labeled with an expiration date of 6/11/23. QMA 3 indicated the resident was still receiving the medication nightly and the medication should have been disposed of on 6/11/23. 2. On 6/14/23 at 2:05 p.m., the 2D Medication Cart was observed with LPN 1. The following medications were found in the cart: a. There was Aller-flo nasal spray, Refresh Tears, Combigan (eye drops), and a Novolog insulin vial opened on 5/1/23 in a drawer with no label. b. Resident 153's had two vials of Lantus insulin 100 unit/mL vial that were opened on 4/1/23 and 5/1/23. She had a Humalog 100 unit/mL vial that was opened on 5/1/23. c. Resident 21's Humalog insulin vial was opened on 5/1/23. d. Resident 118's Humalog insulin vial was opened on 5/1/23. LPN 1 indicated each bottle should have an appropriate label with the name of medication, name of resident, and instructions for use. The insulin vials were only good for 28 days after opening so they should have been disposed of prior to 6/14/23. 3. On 6/14/23 at 3:35 p.m., the 1A Medication Cart was observed with QMA 4. An unlabeled vial of		cart and reordered. Family and physicians were notified. Physician gave no new orders. Residents are 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 on each unit's medication cart was complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on expired medication. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit medication carts (5) times a week per unit for (6) months to ensure no expired medications are in the carts. 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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	insulin lispro 100 unit/mL was observed with an opened date of 5/1/23. QMA 4 indicated the medication was expired 28 days after opening. Interview with the Director of Nursing on 6/15/23 at 2:01 p.m., indicated the insulin medications should have been disposed of after 28 days or the manufacturer's recommendations and all medications should have had appropriate labels in the medication carts. 3.1-25(j) 3.1-25(o)			
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 - §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	F 0812	**The corrective actions that**	07/07/2023

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	failed to follow proper sanitation and food handling practices related to the high temperature dish machine not reaching appropriate rinse temperature and use of expired sanitizer test strips for 1 of 1 kitchens. This had the potential to affect 170 residents who received food from the kitchen. (The Main Kitchen) Findings include: 1. On 6/14/23 at 9:40 a.m., the Dietary Food Manager (DFM) was observed wiping down a preparation counter with a sanitizer solution. At the time, a sanitizer test strip was used to test the solution. The test strips expired on 6/30/22. The strip did not have a readily discernable color change. The DFM brought another package of test strips to test the solution, which had expired on 3/1/22. The strip did not have a readily discernable color change. Interview with the DFM at the time indicated he would send someone out to purchase sanitizer test strips that were not expired. The Sanitation Bucket Log for the month of June 2023, received from the Executive Director on 6/15/23 at 3:51 p.m., indicated three buckets in the morning and three buckets in the evening were checked for correct sanitation levels. There were no sanitation levels written, only check marked that it was completed. The instructions indicated to hold the strip still in the water for 10 seconds and the correct sanitation level was between 150-400 parts per million (ppm). 2. On 6/14/23 at 9:46 a.m., the dishwasher machine was observed to be in use. The dishwasher was a		**were accomplished for those residents to have been affected by the practice are:** Sanitizer test strips were replaced. Screw was removed from the booster, dishwasher was re-ran and reached adequate temperature. Residents are 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 affective by this deficiency. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Dietary staff were educated on not using expired sanitizer test strips and booster was repaired. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** FSD/designee will conduct monthly audits of test strips to ensure they are not expired for (6) months. FSD/designee will conduct daily audits for (6) months to final rinse cycle reaches 160 degrees. FSD/designee will report audit findings to the QAPI committee monthly for (6) six months. The	

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	06/16/2023

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

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	high temperature dishwasher. The wash cycle reached 160 degrees Fahrenheit and the final rinse reached 160 degrees Fahrenheit. The U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code indicates the following standard for proper sanitation temperatures: High Temperature Dishwasher (heat sanitization): " Wash - 150-165 degrees F; " Final Rinse - 180 degrees F; Interview with the DFM at the time indicated the rinse cycle should reach 180 for final rinse for high temperature dishwasher and the temperature logs indicated the same parameters. He would have to shut down the dishwasher and have the service company assess and fix the machine. A follow-up interview on 6/15/23 at 3:45 p.m. with the DFM indicated the service company had assessed the dishwasher and the booster was not working properly, so they had to order a part to fix the problem. They would continue to use their other dishwasher in the meantime to sanitize dishware. 3.1-21(i)(3)		QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	