

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155604	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2013
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NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY REHAB AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 N 14TH ST LAFAYETTE, IN 47904
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December, 16, 17, 18, 19 and 20, 2013</p> <p>Facility number: 000535 Provider number: 155604 AIM number: 100267250</p> <p>Survey team: Rita Mullen, RN, TC Michelle Carter, RN Bobette Messman, RN Maria Pantaleo, RN</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 15 Medicaid: 56 Other: 25 Total: 96</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on December 30, 2013.</p>	F000000	<p>St. Anthony Health Care, Inc. is requesting paper compliance to the Recertification and State Licensure Survey completed on December 20, 2014. "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, St. Anthony Health Care, Inc. does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
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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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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to implement a care plan intervention and follow the facility policy for fall prevention for 1 of 3 residents reviewed for falls (Resident #71).</p> <p>Findings include:</p> <p>During an interview, on 12/16/13 at 3:12 p.m., with LPN #1 she indicated Resident #71 had fallen two or three weeks ago.</p> <p>The clinical record of Resident #71 was reviewed on 12/18/13 at 10:00 a.m.</p> <p>Diagnoses included, but were not limited to, diabetes, obesity, high blood pressure, Alzheimer's disease, depression and arthritis.</p> <p>A Fall Risk Assessment, dated 8/7/13 and updated quarterly, indicated Resident #71 had a score of 18 on 9/22/13 and a score of 20 on 11/9/13. A score of 10 or more is a fall risk.</p>	F000282	<p>F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN I. Resident #71 had call light placed within reach and mat replaced at time of observation. II. Residents who utilize mat in front of toilet were identified. Audit completed to ensure mats were in place. All Residents who currently reside in the facility have the potential to be effected regarding call light being in place. Resident Ambassadors completed room rounds to ensure call lights in place for all Resident's after observation.III. Protocol for housekeeping developed on procedure for changing mats in front of toilet; also included in part of new employee orientation process. Housekeeping was in-serviced on procedure of changing mats. Nursing staff was in-serviced on importance of call lights being within reach for all residents.IV. Plant Operation Director or designee will complete audits to ensure mats in front of toilets are in place daily times 30 days, then weekly x 4 weeks, and monthly thereafter. Director of Nursing or designee will do audits of 10% of population identified to ensure call lights are within reach for the Residents. Call light audits</p>	01/19/2014			

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	<p>A Nursing Note, dated 11/9/13 at 3 a.m., indicated "...entered res [resident] room et [and] found res sitting on BR [bathroom] floor in front of toilet. Res stated 'I slipped.'... no injuries noted. MAEW [moves all extremities well]. Assisted on to feet with assist of 3. Toileted and assisted back to bed. Res denies pain. MD notified neuro checks started...."</p> <p>A Fall care plan, dated 8/7/13 and updated quarterly, indicated a bed alarm was initiated on 11/9/13, non skid socks were to be worn when shoes were off as the resident allowed on 11/11/13, added to the "Falling Star Program" on 11/12/13, and mat on the floor in front of the toilet was initiated on 11/12/13.</p> <p>During an observation on 12/19/13 at 1:15 p.m., Resident #71 was sitting in her room, in a recliner, eating lunch. The Nurse call light was not within reach. The call light was on the bedrail next to the wall behind the resident. There was no mat in front of the toilet in the bathroom.</p> <p>During an interview with the unit manager, on 12/19/13 at 1:45 p.m., she indicated the floor mat was part of the care plan to prevent falls and it was not on the floor in front of the</p>		<p>will be weekly x 4 weeks, monthly x 4 months and then quarterly thereafter. The results of the audits will be submitted Quality Assurance Committee and continue at the discretion of the Quality Assurance Committee. V. COMPLETION DATE: 01/19/14</p>	

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	<p>toilet. She indicated the mat was a non-skid mat that fit around the toilet.</p> <p>During an interview with the Housekeeping Manager, on 12/19/13 at 1:50 p.m., she indicated the mat was for people that miss the toilet, not for fall prevention and she indicated the mats were changed about every 2 days and this resident's mat had not been put back in her bathroom.</p> <p>A Fall Prevention Policy, dated 10/11, received from the unit manager on 12/20/13 at 1 p.m., indicated the following:</p> <p>"...Procedure</p> <p>...9. Standard protocol approaches for all residents is as follows and will not be repeated in each resident's care plan:</p> <p>...b. Maintain call light within easy reach</p> <p>c. Appropriate footwear when up..."</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to implement fall prevention interventions for 1 of 3 residents reviewed for falls (Resident #71).</p> <p>Findings include:</p> <p>During an interview, on 12/16/13 at 3:12 p.m., with LPN #1 she indicated Resident #71 had fallen two or three weeks ago.</p> <p>The clinical record of Resident #71 was reviewed on 12/18/13 at 10:00 a.m. The Resident was admitted to the facility on 8/7/13.</p> <p>Diagnoses included, but were not limited to, diabetes, obesity, high blood pressure, Alzheimer's disease, depression and arthritis.</p> <p>A Fall Risk Assessment, dated 8/7/13 and updated quarterly, indicated Resident #71 had a score of 14 on 8/7/13, a score of 18 on 9/22/13 and a score of 20 on 11/9/13. A score of</p>	F000323	<p>F 323 FREE OF ACCIDENTS HAZARDS/SUPERVISION/DEVI CE I. Resident #71 had call light placed within reach and mat replaced at time of observation. II. Residents who utilize mat in front of toilet were identified. Audit completed to ensure mats were in place. All Residents who currently reside in the facility have the potential to be effected regarding call light being in place. III. Protocol for housekeeping developed on procedure for changing mats in front of toilet; also included in part of new employee orientation process. Housekeeping was in-serviced on procedure of changing mats. Nursing staff was in-serviced on importance of call lights being within reach and fall prevention policy and interventions for all residents. IV. Plant Operation Director or designee will complete audits to ensure mats in front of toilets are in place daily times 30 days, then weekly x 4 weeks, and monthly thereafter. Director of Nursing or designee will do audits of 10% of population identified to ensure call lights are within reach for the Residents. Call light audits will be weekly x 4 weeks, monthly</p>	01/19/2014			

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	<p>10 or more is a fall risk.</p> <p>An Occurrence report, dated 9/22/13, indicated Resident #71 fell forward bending over from a standing position while picking up a fork in the dining room. The resident's shoes, flip flops, were removed from the resident's room with the resident's permission.</p> <p>A Nursing Note, dated 11/9/13 at 3 a.m., indicated "...entered res [resident] room et [and] found res sitting on BR [bathroom] floor in front of toilet. Res stated "I slipped"... no injuries noted. MAEW [moves all extremities well]. Assisted on to feet with assist of 3. Toileted and assisted back to bed. Res denies pain. MD notified neuro checks started...."</p> <p>A Fall care plan, dated 8/7/13 and updated quarterly, indicated a bed alarm was initiated on 11/9/13, non skid socks were to be worn when shoes were off as the resident allowed on 11/11/13, added to the "Falling Star Program" on 11/12/13, and a mat to floor in front of toilet was initiated on 11/12/13.</p> <p>A current Resident Assignment sheet received from the unit manager on 12/19/13 at 2:00 p.m., indicated Resident #71 used the call light, the</p>		<p>x 4 months and then quarterly thereafter. The results of the audits will be submitted Quality Assurance Committee and continue at the discretion of the Quality Assurance Committee. V. COMPLETION DATE: 01/19/14</p>				

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	<p>high heeled flip flop were removed from the room on 9/23/13, bed alarm was added on 11/9/13 and a mat to floor around the toilet was added on 11/12/13.</p> <p>During an observation on 12/19/13 at 1:15 p.m., Resident #71 was sitting in her room, in a recliner, eating lunch. The Nurse call light was not within reach. The call light was on the bedrail next to the wall behind the resident. There was no mat in front of the toilet in the bathroom.</p> <p>During an interview with QMA (qualified medication assistant) #2 on 12/19/13 at 1:19 p.m., she indicated Resident #71 is mobile and does her own care but the call light should be next to her. QMA #2 moved the call light to within reach of the resident.</p> <p>During an interview with the unit manager, on 12/19/13 at 1:45 p.m., she indicated the floor mat was part of the care plan to prevent falls and it was not on the floor in front of the toilet. She indicated it was a non-skid mat that fit around the toilet.</p> <p>During an interview with the Housekeeping Manager, on 12/19/13 at 1:50 p.m., she indicated the mat was for people that miss the toilet, not</p>			

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	<p>for fall prevention. She indicated the mats were changed about every 2 days and this resident's mat had not been place back in her bathroom.</p> <p>A Fall Prevention Policy, dated 10/11, received from the unit manager on 12/20/13 at 1 p.m., indicated the following:</p> <p>"...Procedure</p> <p>...4. The CNA [certified nursing assistant] Kardex will be updated to reflect the interventions</p> <p>...9. Standard protocol approaches for all residents is as follows and will not be repeated in each resident's care plan:</p> <p>...b. Maintain call light within easy reach</p> <p>c. Appropriate footwear when up..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F000362 SS=E	<p>483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</p> <p>Based on observation, record review and interview, the facility failed to ensure sufficient dietary support personnel for timely meal service for 4 of 4 meal observations. This deficit practice had the potential to impact 95 of 96 residents the received meals from the kitchen.</p> <p>Findings include:</p> <p>On 12/17/13 at 11:45 a.m., the dining room was observed during lunch.</p> <p>Residents were observed waiting 25 minutes to 35 minutes for lunch service after they had been seated in dining. The posted lunch time was 11:45 a.m.</p> <p>On 12/17/13 at 12:10 p.m., 8 dining room serving staff were observed to be waiting for trays to be prepared for service to the residents.</p> <p>On 12/17/13 at 12:15 p.m., the kitchen staff were observed during preparation of lunch trays.</p> <p>A staff member placed written</p>	F000362	<p>F362 Sufficient Dietary Support Personnel I. Meal service was reviewed to determine more efficient means of a delivery process to the residents in the main dining room. II. All residents who currently reside in the facility have the potential to be affected by meal service not being served in a timely manner. III. Dietary staff will be educated on the importance of serving meal trays in dining room in a timelier manner. Dining room meal service will be reorganized to include the prior set up of resident's dining room tables to include resident's beverage preference and table condiments. The tray line process will be reorganized to enhance the efficiency of the delivery system. This practice will reduce the preparation time of the meal trays, therefore reducing the amount of time staff members are waiting in line. This practice will also reduce the meal service time. IV. Meal service will be timed in dining room daily x 4 weeks, weekly x 4 months, quarterly x 2. Results to be submitted to the QA team and will continue at the discretion of QA team. V. Compliance date 1/19/2014</p>	01/19/2014

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	<p>resident lunch request on luncheon tray. Then the cook prepared and placed the entree food request on the tray. The Director of Dining Services placed drinks and dessert on luncheon tray. The tray was then ready to be served to resident and was placed on serving cart . Staff in the dining room were lined up to receive luncheon trays for residents.</p> <p>On 12/17/13 at 12:15 p.m., it was observed that there were 6 staff in kitchen area but only 3 staff were preparing lunch trays.</p> <p>On 12/18/13 at 12:10 p.m., 9 dining room serving staff were observed to be waiting for trays to be delivered from the kitchen area for the residents.</p> <p>On 12/19/13 at 6:10 p.m., 7 dining room serving staff were observed to be waiting for trays to be delivered from kitchen area for residents.</p> <p>On 12/20/13 at 8:10 a.m., 6 dining room staff were observed waiting for trays to be delivered from kitchen area for residents.</p> <p>On 12/20/13 at 8:30 a.m., during an interview with the Director of Dining Services, she indicated the meal</p>			
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	<p>preparation and delivery of resident meals had always been conducted in the manner observed.</p> <p>On 12/20/13 at 3:00 p.m., a policy titled "Dining Room and In -Room Meal Tray Delivery Dining" was provided by the Dining Service Director and indicated the trays were to be delivered to appropriate locations within ten minutes in order to maintain proper temperatures.</p> <p>3.1-20(h)</p>			

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure food temperatures were palatable for 1 of 4 meal observations. This deficit practice had the potential to impact 95 of 96 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>On 12/17/13 at 9:44 a.m., during an interview with Resident #9, she indicated that the food was cold on numerous days and at different meal times.</p> <p>On 12/19/13 at 6:12 p.m., during an interview with Resident #9, she indicated that the soup was cold while she was in dining room and had just been served her meal.</p> <p>On 12/19/13 at 6:20 p.m., during a kitchen food service test tray observation and demonstration, the Director of Dietary Services tested the soup to be 110 degrees Fahrenheit.</p>	F000364	<p>F 364 Nutritive value / Appear, Palatable / Prefer temp. I. Facility was not made aware of concerns voiced by resident #9 prior to the exit interview; therefore no immediate action was taken. However resident #9 was interviewed following the survey and her concerns were addressed. II. All residents currently residing in the facility have the potential to be affected by inappropriate food temperatures. III. All dietary staff will be educated on the importance of food temperatures. Temperature will be taken and recorded throughout the meal. Temperature logs will be implemented to ensure all food leaves the kitchen at 135 degrees or higher for hot food and 41 degrees or lower for cold food. Log sheets will indicate temperature checks at: Start (S), Mid (M), End (E) of each meal. IV. Food temperatures will be checked daily for 4 weeks, weekly for 4 months and then quarterly x 2. Results to be submitted to QA team and continue at the discretion of QA team. V. Compliance date 1/19/2014</p>	01/19/2014

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NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY REHAB AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 N 14TH ST LAFAYETTE, IN 47904
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	<p>On 12/19/13 at 6:22 p.m., during an interview, with the Director of Dietary Services, she indicated the temperature for the soup should have been 120 degrees or higher. She also indicated she would have to reheat the food items.</p> <p>On 12/20/13 at 3:00 p.m., a policy titled "Dining Room and In -Room Meal Tray Delivery Dining" was provided by the Dining Service Director and indicated the trays were to be delivered to appropriate locations within ten minutes in order to maintain proper temperatures.</p> <p>3.1-21(a)(2)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to correctly transcribe a medication order for 1 of 5 residents reviewed for unnecessary medications (Resident #87) and to update a care plan regarding the wearing of high heeled flip flops for 1 of 3 residents reviewed for falls (Resident #71).</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 87 was reviewed on 12/19/2013 at 10:10 a.m.</p> <p>Diagnoses included, but were not limited to, hypothyroidism.</p> <p>Physician order indicated the</p>	F000514	F 514 RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE I. Resident # 87 medication order clarified to the correct dosage on 12/20/13. Resident #71 care plan updated with removal of flip flops on 12/20/13. II. Residents that may also be affected will be identified by a facility audit of Medication Administration Record (MAR) for discrepancy in transcriptions of orders. Residents that may be affected will be identified by a facility audit of care plans and Resident kardex to ensure fall interventions are present on the care plan. III. Nursing staff will be in-serviced on transcription of orders. Unit Coordinator or designee will verify the order was transcribed correctly on the MAR after completion by the primary nurse. During Resident Safety Meeting care plans and kardexs	01/19/2014			

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	<p>following on 7/9/2012 at 3:00 p.m., "Chg. [Change]Levothyroxine to 275 mcg. [micrograms] P.O. [by mouth] qd [every day]".</p> <p>Medication Administration Record (MAR) indicated Levothyroxine 0.175 mg (milligram) tab give 100 mg oral daily at 6:00 a.m., for hypothyroidism and levothyroxine 0.1 mg tab give with 175 mg to equal 275 mg oral daily at 6:00 a.m., for hypothyroidism.</p> <p>On 12/20/2013 at 1:00 p.m., during an interview with the Unit Coordinator, she indicated the order was transcribed incorrectly and should have been written in micrograms not milligrams. She indicated the medications sent from the pharmacy was the correct dose.</p> <p>On 12/20/2013 at 1:10 p.m., observation of resident medication packet indicated the correct dose was sent from pharmacy for resident.</p>		<p>will be reviewed to ensure interventions are present. Care Plans and Resident kardex will be reviewed on a quarterly basis according to the MDS schedule and as needed. IV. Director of Nurses or designee will complete an audit of Physician Orders of 10% of the population for correct transcriptions of orders weekly x 4 weeks, monthly x 4 months, and then quarterly thereafter. Director of Nurses of designee will complete an audit of care plans and Resident kardex to ensure interventions are present on 10% of the population weekly x 4 weeks, monthly x 4 months, and then quarterly thereafter. The results of the audits will be submitted Quality Assurance Committee and continue at the discretion of the Quality Assurance Committee. V. COMPLETION DATE: 01/19/14</p>		

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	<p>2. During an interview, on 12/16/13 at 3:12 p.m., with LPN #1 she indicated Resident #71 had fallen two or three weeks ago.</p> <p>The clinical record of Resident #71 was reviewed on 12/18/13 at 10:00 a.m. The Resident was admitted to the facility on 8/7/13.</p> <p>Diagnoses included, but were not limited to, diabetes, obesity, high blood pressure, Alzheimer's disease, depression and arthritis.</p> <p>A Fall Risk Assessment, dated 8/7/13 and undated quarterly, indicated Resident #71 had a score of 14 on 8/7/13, a score of 18 on 9/22/13 and a score of 20 on 11/9/13. A score of 10 or more is a fall risk.</p> <p>An Occurrences report, dated 9/22/13, indicated Resident #71 fell forward bending over from a standing position while picking up a fork in the dining room. The Resident's shoes, flip flops, were removed from the resident's room with the resident's permission.</p>				

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	<p>A Nursing Note, dated 11/9/13 at 3 a.m., indicated "...entered res [resident] room et [and] found res sitting on BR [bathroom] floor in front of toilet. Res stated 'I slipped'... no injuries noted. MAEW [moves all extremities well]. Assisted on to feet with assist of 3. Toileted and assisted back to bed. Res denies pain. MD notified neuro checks started...."</p> <p>A Fall care plan, dated 8/7/13 and updated quarterly, indicated a bed alarm was initiated on 11/9/13, non skid socks were to be worn when shoes were off as resident allowed on 11/11/13, added to the "Falling Star Program" on 11/12/13, and mat to floor in front of toilet was initiated on 11/12/13. Preventing the resident from wearing the high heeled flip flops was not on the care plan.</p> <p>A current Resident Assignment sheet received from the unit manager on 12/19/13 at 2:00 p.m., indicated Resident #71 used the call light, the high heeled flip flop were removed from the room on 9/23/13, bed alarm was added on 11/9/13 and a mat was placed on the floor around the toilet on 11/12/13.</p> <p>During an interview with the Unit</p>			

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	<p>Manager, on 12/19/13 at 2:15 p.m., she indicated the removal of the high heeled flip flops, to prevent the resident from wearing them, was added to the CNA (certified nursing assistant) Kardex but not added to the care plan.</p> <p>3.1-50(a)(2)</p>			