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	10/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00359994, IN00361837, IN00362842, and IN00363673. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00359994 - Substantiated. Federal/State deficiencies related to the allegations are cited at F604. Complaint IN00361837 - Unsubstantiated due to lack of evidence. Complaint IN00362842 - Substantiated. Federal/State deficiencies related to the allegations are cited at F676, F677, F686, and F880. Complaint IN00363673 - Substantiated. Federal/State deficiencies related to the allegations are cited at F676, F677, F804, and F812. Survey dates: September 28, 29, and 30, 2021 and October 1, 2021 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 143 SNF: 22 NCC: 1 Total: 166 Census Payor Type:	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicare: 30 Medicaid:101 Other: 35 Total: 166 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/5/21.			
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility			

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	must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.			
	Based on observation, record review, and interview, the facility failed to ensure a resident with a bed and chair alarm for interventions for resident falls, was assessed for the least restrictive interventions and use of the alarms, for 1 of 1 residents reviewed for alarms. (Resident F) Finding includes: During an observation on 9/28/21 at 3:43 p.m., a CNA was assisting the resident from her bed to the Wheel Chair. An alarm was located on the wheelchair. Resident F's record was reviewed on 9/30/21 at 3:01 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set assessment, dated 8/26/21, indicated a severely impaired cognition status, rejected care one to three days, wandered four to six days, required extensive assistance for transfers, limited assistance with locomotion, had two falls with no injury, and a chair alarm was used daily. A Care Plan, dated 12/17/20, indicated she was a risk for falls related to poor safety awareness. The interventions included, a movement alarm was to be applied to the bed and the wheelchair. The Physician's Orders indicated an order, dated 7/12/21, for a movement alarm to be applied to	F 0604	F604 1:1 Regarding F an adaptive device review evaluation was completed for this resident's bed & chair safety alarms/devices proving it was not a restraint. 1:2 Residents requiring adaptive equipment had an adaptive device review evaluation completed to determine if the device was a restraint. No restraints noted upon completion of the evaluations. 1:3 The Director of Staff Development/designee re-in-serviced Licensed Staff on the adaptive equipment review evaluation. The IDT will review the medical record/24-hour report of residents who have new orders for adaptive equipment to ensure an adaptive equipment device evaluation was completed as well as ensuring the adaptive equipment device is not a restraint the following business day in the morning clinical meeting for six (6) months. 1:4: The DON/Designee will report audit findings to the QAPI committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for	10/18/2021

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	the wheelchair and on 9/9/21 an alarm was to be applied to the bed. The Fall Assessments, dated 7/9/21, 8/8/21, 8/25/21, and 9/9/21, indicated a risk for falls. A Nurse's Progress Note, dated 8/8/21 at 3:40 p.m., indicated the resident was found sitting on the floor in front of the wheelchair. She had stated she tried to get up and fell. A Nurse's Progress Note, dated 8/8/21 at 10:11 p.m., indicated she continued to stand on her own from the wheelchair and was being redirected by the staff. The staff attempted to transfer her to bed and she continued to get up on her own and tried to ambulate. A Fall Investigation, dated 8/8/21, indicated the she was attempting to get out of the wheelchair without assistance. She had a gait imbalance and was not able to ambulate on her own. The Interdisciplinary Team Note, dated 8/9/21 at 9 a.m., documented on 8/26/21, indicated anti-rollback brakes were added to the wheelchair. A Nurse's Progress Note, dated 9/9/21 at 12:15 a.m., indicated the she was found on the mat beside her bed. The bed alarm was in place and was sounding. She indicated she had to use the bathroom. A Fall Investigation, dated 9/9/21, indicated she had gotten up out of bed to take herself to the bathroom and the movement alarm was activated. An Interdisciplinary Team Note, dated 9/9/21 at 10:29 a.m., indicated there were no injuries due		any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be complete -18-21	

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	to the fall and a movement alarm was applied to the bed. An interview with Employee 4, on 9/30/21 at 9:54 a.m., indicated the resident needed assistance with transfers and would attempt to get up on her own. Her gait was unsteady and she held on to items when she was standing. She had an alarm on her bed and chair so the staff would know when she was getting up on her own. The staff attempted to keep her busy with daily activities. During an interview with the Executive Director on 9/30/21 at 4:40 p.m., she indicated an assessment for the chair and bed alarms had not been completed. A facility policy, titled, "Use of Restraints", dated 4/2017, received as current from the Executive Director as current, indicated restraints would only be used to treat the resident's medical symptom(s) and never for the prevention of falls. Prior to restraint use, a pre-restraining assessment would be completed and reviewed for determination of the need for the restraints, the possible underlying causes of the problems, and for the determination of the less restrictive interventions. This Federal tag relates to Complaint IN00359994. 3.1-3(w) 3.1-26(o)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with			

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	the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			
	Based on observation, record review, and interview, the facility failed to ensure a resident who required limited assistance with eating was assisted with the lunch meal in a timely manner	F 0676	F676 1:1 Regarding resident C, she was assisted by the staff with her lunch meal. No	10/18/2021

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	and received limited assistance for eating as Care Planned, for 1 of 3 residents observed and reviewed for meal assistance. (Resident C) Finding includes: During an observation on 9/29/21 at 12:04 p.m., Resident C was lying in bed, the lunch tray was delivered to her room by Employee 1. The over the bed table was placed in front of the resident and Employee 1 prepared the meal. Employee 1 then moved the bedside table with the meal tray on it away from the resident's reach and she exited the room. The thermal plate cover over the food was partially off the plate. The plate was observed to have mashed potatoes, ground beef which had the appearance of a sloppy Joe, and brussel sprouts. Employee 1 returned to the room and completely fed the resident her meal at 12:17 p.m. with no attempt to involve the resident. Resident C's record was reviewed on 9/29/21 at 3:30 p.m. The diagnoses included, but were not limited to, dementia. A Significant Change Minimum Data Set assessment, dated 8/2/21, indicated a severely impaired cognition status and required limited assistance with eating. A Care Plan, dated 8/3/21, indicated limited assistance was needed with eating. This Federal tag relates to Complaints IN00362842 and IN00363673. 3.1-38(2)(D)		adverse reactions were noted. 1:2 Nurse Managers/designees monitored meal services that day & did not observe any of the residents not being served or assisted with meals in a timely manner. 1:3 The Director of Staff Development/designee re-in-serviced the staff on the importance of serving the resident meals in a timely manner as well as assisting/conversing with the residents during meals. The Nurse Manager/designee will monitor five (5) meals per unit per week to ensure meals are served in a timely manner as well as staff/resident interactions are occurring during meals for six (6) months. 1:4 The DON/Designee will report audit findings to the QAPI committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be complete by 10-18-21	

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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 observation, record review, and interview, the facility failed to ensure a resident who was dependent on staff for transfers, was transferred back to bed in a timely manner, for 1 of 6 residents reviewed for activities of daily living (ADL's). (Resident J) Finding includes: During an observation on 9/28/21 at 3:54 p.m., Resident J was sitting in the wheelchair in her room. Employee 5 had applied the mechanical lift sling to the sit-to-stand mechanical lift, which was positioned in front of the resident and the wheelchair. Employee 5 then exited the room and indicated, when Employee 6 returned to the hallway, they would transfer the resident back to her bed from the wheelchair. There was no battery observed in the the mechanical lift. Employee 6 returned to the hallway on 9/28/21 at 4 p.m. On 9/28/21 at 4:08 p.m., Resident J remained in the wheelchair and the sit-to-stand lift was still hooked to the sling, which went around the resident's back. Resident J indicated she had been up for a long time and wanted to go back to bed and the staff were supposed to be getting a battery for the lift. On 9/28/21 at 4:12 p.m., Employee 5 exited the Nurses' Station and indicated he was leaving the	F 0677	F677 1:1 Regarding resident J the Registered Nurse assessed her without findings. This resident is alert & oriented to person, place, & time. She verbally stated that she agreed to being connected to the mechanical lift while the battery charged. Denied pain/discomfort. 1:2 The DNS/designee completed rounds house wide & did not observe other residents/have other residents voice concerns related to being up in their w/c & not assisted to bed timely. Nurse Manager/designee audited resident medical records who are dependent on staff for transfers to ensure their preferences for being out of bed/up in w/c were accurate. Care plans & Kardex were updated at that time. 1:3 The Director of Staff Development/designee re-in-serviced the staff on proper battery charging for all mechanical lifts as well as ensuring residents are not connected to the mechanical lift until the time of transfer. The Director of Staff Development/designee	10/18/2021

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	hallway to go on break. On 9/28/21 at 4:21 p.m., the resident remained in the wheelchair and the sling remained hooked up to the mechanical lift. Her head was down and eyes were closed. During an interview on 9/28/21 at 4:29 p.m., Employee 6 indicated the employee breaks were usually 15-20 minutes. Employee 6 then entered Resident J's room, after being made aware she was hooked to the mechanical lift. The resident voiced to Employee 6 she had been waiting a long time and Employee 5 left her room to find a battery for the lift and had not been back. She stated she had been up for lunch. She indicated the mechanical lift did not need to be unhooked. On 9/28/21 at 4:35 p.m., Employee 6 obtained a battery for the lift and informed the resident when Employee 5 returned they would transfer her back into the bed. On 9/28/21 at 4:39 p.m., Employee 5 returned to the hallway and used the mechanical lift to transfer the resident from the wheelchair to the bed. Employee 6 indicated the resident was only to be up in a chair for two hours and the resident indicated she had been up for at least three hours. Resident J's record was reviewed on 10/1/21 at 10 a.m. The diagnoses included, but were not limited to, spinal stenosis. An Admission Minimum Data Set assessment, dated 8/12/21, indicated an intact cognition and required extensive assistance of two for transfers. A Care Plan, dated 8/10/21, indicated assistance		re-in-serviced the staff regarding resident preferences for being out of bed per the Kardex/assisting residents back to bed in a timely manner. The Nurse Manager/designee will observe 3 transfers per unit five (5) times a week for six (6) months to ensure timely transfers are occurring. 1:4: The DON/Designee will report audit findings to the QAPI committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be complete by 10-18-21	

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	was needed for ADL's. The interventions included, extensive assistance of two was needed for transfers. A Physician's Order, dated 9/9/21, indicated a sit-to-stand lift was to be used for transfers to facilitate sitting in a wheelchair for two hours daily. This Federal tag relates to Complaints IN00362842 and IN00363673. 3.1-38(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, record review, and interview, the facility failed to ensure a treatment for a pressure ulcer wound was in place as ordered by the Physician, for 1 of 3 residents reviewed for pressure ulcer wounds. (Resident C) Finding include:	F 0686	F686 1:1 Regarding resident C, the treatment was completed per order & peri care was provided. No adverse reactions were noted. 1:2 The Wound Nurse/designee completed rounds on residents	10/18/2021

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	Resident C's pressure ulcer wounds were observed with the Wound Nurse, the Unit Manager, and Employee 2, on 9/30/21 from 9:01 a.m. through 9:45 a.m. The resident had been incontinent of bowel movement and Employee 2 and the Unit Manager provided incontinent care, which included the sacrum area. There was no dressing on the pressure ulcer wound located on the sacrum. The Unit Manager indicated she thought the dressing had come off in the incontinent brief. The brief was then observed and there was no dressing in the soiled brief. Employee 2 indicated the brief had been changed at approximately 7:20 a.m. and there had been no dressing on the sacrum at that time. Employee 2 indicated she had informed Employee 3 of the dressing not being being on the sacrum wound. The sacrum pressure wound was measured by the Wound Nurse at 5.2 centimeters (cm) by 4.4 cm x 0.3 cm with 50% of the area covered by gray colored slough. There was a new open area found on the left upper buttock, which measured 1 cm x 2.4 cm by 0.1 cm. Resident C's record was reviewed on 9/29/21 at 3:30 p.m. The diagnoses included, but were not limited to, dementia A Significant Change Minimum Data Set assessment, dated 8/2/21, indicated a severely impaired cognitive status, required extensive assistance of two for bed mobility, dependent on two for transfers, extensive assistance for hygiene, dependent on two for toileting, was always incontinent of bowel movement, had three stage one (intact reddened skin) pressure ulcers, one stage two (partial thickness of skin loss) pressure ulcer, and had one unstageable (slough		with dressing changes to ensure the dressings were dry & intact. No concerns noted. 1:3 The Director of Staff Development/designee re-educated the nursing staff regarding the potential adverse reactions of dressings not being intact per Physician's orders. The Nurse Manager/designee will conduct 3 random rounds on each unit five (5) times a week to ensure dressings are dry & intact for six (6) months. 1:4: The DON/Designee will report audit findings to the QAPI committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be complete by 10-18-21	

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	or necrotic tissue present) pressure ulcer wound present on admission. A Care Plan, dated 7/29/21, indicated impaired skin integrity. Treatment as ordered by the Physician was an intervention. A Physician's Order, dated 9/16/21, indicated the sacrum wound was to cleansed, patted dry, and a dry dressing was to be applied on Tuesdays, Thursdays, and Saturdays. This Federal tag relates to Complaint IN00362842. 3.1-40(a)(2)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to serve meals to the residents' rooms in a timely manner and failed to serve the food at an appetizing temperature, for 2 of 5 Hallways observed during 3 of 3 meal observations. (Hallways 2D and 3D) Findings include:	F 0804	F804 1:1 No adverse reactions were noted upon assessment of the residents who did not receive their dinner in a timely manner. 1:2 The Nurse Managers/designee observed the residents at lunch/dinner meals the next day to	10/18/2021

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	A Confidential Family interview indicated the supper meals were usually served cold and sat on the tray delivery cart for long periods of time before staff would deliver them to the residents. An interview with Resident K, on 9/28/21, indicated the food was not always served hot. 1) On 9/28/21, during an observation of the evening meal on Hallway 2D, where 10 residents resided, the meal trays arrived to the hallway on a non-heated cart, with the plates on each tray covered with a thermal cover, at 4:31 p.m. Employee 5 and 6 began delivering the supper meals to the residents' in the rooms at 4:55 p.m. 2) During an observation of the 3D Unit, where 19 residents resided, the evening meal arrived on 9/29/21 at 5:39 p.m. The meals arrived on an uncovered/non-heated cart, with thermal covers over the plates on the trays. The Executive Director, Dietary Manager, and Director of Nursing, along with Employees 7 & 8, who were assigned to the Hallway, began delivering the evening meal to the residents in their rooms at 5:43 p.m. The last tray was served at 5:58 p.m. The temperatures of the food served on a sample tray at 5:58 p.m. indicated the ravioli was 126.4 and tasted luke warm. The cauliflower served was 129.5 and was cool to taste. The Dietary Manager at the time of the of the temperatures/tasting, indicated 135 was the serving temperature and the temperature of the ravioli and cauliflower were within range. He indicated when the thermal lid was taken off the plate, the food would get cooler.		ensure staff were following the proper procedure when serving meals & assisting the residents with their meals. The staff on 2D & 3D were re-in-serviced on the proper process of serving meals to residents who eat in their rooms & to the residents who need assistance with meals in the dining room. Managers have also been assigned to assist with meals on each unit to ensure the residents are served timely & assist with feeding the residents as necessary. 1:3 The Staff Development/designee re-in-serviced the dining & nursing staff on the proper procedure when serving meals to residents who eat in their rooms & to the residents who need assistance with meals in the dining room. The Nurse Managers/designee will observe (2) meal services for breakfast, lunch, & dinner per unit weekly to ensure the process is flowing correctly & the residents are being assisted with meals timely for six (6) months. The Director of Dining Services/designee will audit random resident food trays 4 times a week on various units to ensure appropriate temperatures are being maintained for six (6) months. Routine food temperatures will continue to be taken & audited by the Director of Dining Services/designee. 1:4:	

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	During an interview on 9/30/21 at 9 a.m., the Executive Director indicated there was not a policy for what temperature the food was to be when served to the residents. A facility policy, titled, "Food Production", dated 3/2019, and received from the Executive Director as current, indicated Foods would be served at the appropriate temperature. This Federal tag relates to Complaint IN00363673.		The DON/Designee will report audit findings to the QAPI committee meeting monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be complete by 10-18-21	
F 0812 SS=D 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, record review, and interview, the facility failed to ensure food was	F 0812	F812 1:1 Regarding resident H no	10/18/2021

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	distributed in accordance with professional standards for food service safety and failed to distribute a meal tray for a resident, for 1 of 3 residents observed during meal service. (Resident H) Finding includes: The following was observed on 9/29/21: At 12:53 p.m., the lunch meal trays arrived on the hallway. At 5:39 p.m., the evening meal trays arrived on the hallway. At 5:43 p.m., the Dietary Manager, Executive Director, and the Director Nursing assisted Employees 7 and 8 serve the evening meal to the residents' rooms. At 5:58 p.m., all evening meals had been delivered to the residents' rooms. At 6:10 p.m., Resident H was lying in bed. There was no meal tray in the room. There was no evening meal tray for Resident H on the tray cart. During an interview on 9/29/21 at 6:15 p.m., Employee 7 indicated Resident H had not eaten her lunch, so she gave the resident the lunch tray at 4:30 p.m. Employee 7 indicated on 9/29/21 at 6:21 p.m., the day shift staff reported the resident had not wanted her lunch meal and they left it in the room on top of the dresser (3-3.5 hours). She warmed up the lunch meal and gave it to her. She was served a sloppy Joe sandwich, green vegetables and applesauce and she ate 100%. During an interview on 9/29/21 at 6:45 p.m., the Executive Director indicated the evening meal tray was found on another cart and it had not been		adverse reactions were noted from this resident eating her lunch tray that evening. Resident H’s dinner tray was on the 3D cart & was delivered to the unit at the same time the other residents meal trays were delivered. 1:2 The Nurse Managers/designee ensured all residents received their dinner meal tray that evening without any concerns noted. The C.N.A. was re-in-serviced on professional standards for food service safety & meal tray distribution. 1;3 The Director of Staff Development/designee re-educated the staff on professional standards for food service safety as well as ensuring all residents receive a meal tray unless contraindicated by a Physician’s order. The Nurse Manager/designee will monitor five (5) meals per unit per week to ensure meals are served in a timely manner as well as meal trays not being left in the resident’s room for six (6) months. 1:4 The DON/Designee will report audit findings to the QAPI committee meeting monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for	

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	offered to the resident. A facility policy, dated 3/2019, titled, "Food Production", received from the Executive Director as current, indicated food that had stood for several hours at room temperature could not be considered safe and free from contamination and should be discarded. This Federal tag relates to Complaint IN00363673. 3.1- 21(i)(3)		continued compliance. 1:5 Systemic changes will be complete by 10-18-21	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread			

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn or not worn properly, failure to sanitize equipment used for multiple residents, uncovered linens in the hallway, and improper handwashing, for 4 of 9 hallways (2B, 2C, 2D [Yellow Zone], and 3C) (Residents J, L, M, N, C, P, and Q) (Employees 5, 9, 10, 1, and 11) Findings include: 1) During observations of the facility's "Yellow Zone" on 9/28/21, the following was observed: At 3:54 p.m., Employee 5 was in Resident J's room and was fastening the sling onto the sit-to-stand mechanical lift. Employee 5 had no isolation gown on, no face shield or goggles were worn, and had not washed his hands upon exiting the room. Employee 5 was stopped and then he completed hand hygiene. He had a black mask on, which he indicated was a KN95 he had brought from home. He then removed the KN95 and put on an N95 mask. At 4:04 p.m., Employee 5 had not yet donned a face shield or goggles for eye protection. At 4:39 p.m., Employee 5 still had not donned a	F 0880	Quality Improvement Initiative (Interventio n and Improvement Plan) Tool p paraid="924862384" paraeid="{5e36d4a5-ec97-411e-9 a09-c43467911c4d}{170}" >QII ID: Directed Plan of Correction: Infection Prevention and Control p paraid="1604476934" paraeid="{5e36d4a5-ec97-411e-9 a09-c43467911c4d}{205}" >Email information to: kdawson@qsource.org (Kara Dawson) p paraid="904677936" paraeid="{5e36d4a5-ec97-411e-9 a09-c43467911c4d}{227}"	10/18/2021

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	face shield or goggles for eye protection. 2) During an observation on the 2C hallway on 9/28/21 at 3:33 p.m., Employee 9 was in Resident L's room, checked a blood pressure and blood sugar reading (glucometer). Employee 9 then exited the room without washing her hands or sanitizing the blood pressure cuff/machine. She then started to enter Resident M's room with the blood pressure machine and was stopped. She took the blood pressure cuff/machine to the Nurses' Station and sanitized it with bleach wipes and used alcohol hand rub on her hands. Employee 9 indicated she had placed the glucometer in her pocket without sanitizing it after use and placed the used lancet in the trash can in the room. 3) During an observations on the 3C hallway, the following was observed: At 5:07 p.m., there was an uncovered basket type cart in the hallway, which had towels, washcloths, pads, and opened packet of briefs in the baskets. The cart was not covered. At 6:21 p.m., Employee 10 had a face shield on and the surgical mask was below her nose. There were no residents in the area. The basket type cart with the linens and briefs, remained uncovered in the hallway. At 6:26 p.m., Employee 10 removed a pad and towel from the uncovered cart, walked down the hallway with her mask under her nose and the face shield on, and entered Resident N's room. When Employee 10 exited Resident N's room, the surgical mask remained under her nose. 4) During an observation on 9/29/21 at 11:51 a.m., Resident C was sitting in a Broda Chair		>Provider Contact Dawson p paraid="1786194681" paraeid="{5e36d4a5-ec97-411e-9a09-c43467911c4d}{244}" >Phone-628-1145 p paraid="1906986419" paraeid="{b3e0c7a6-3402-473d-a12d-b2722f8ba7b6}{5}" >Title Improvement Advisor / Infection Preventionist Consultant p paraid="1250136676" paraeid="{b3e0c7a6-3402-473d-a12d-b2722f8ba7b6}{20}" >Email: kdawson@qsource.org p paraid="2101136509" paraeid="{b3e0c7a6-3402-473d-a12d-b2722f8ba7b6}{36}" >Department:	

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(high back reclining chair). Employees 1 and 11 entered the room and transferred the resident to bed using a mechanical lift. Once the resident was in bed, Employees 1 and 11 donned gloves and positioned the resident after the removal of the mechanical lift sling. Employee 1 then removed the gloves and walked into the hallway without washing or sanitizing her hands. The lunch trays were in the hallway and she started to reach for a lunch tray and was stopped. She then completed hand hygiene.

5) During an observation on 9/30/21 at 8:08 a.m., Employee 11 entered Resident P's room and completed a blood pressure reading with a wrist cuff, temperature check, and oxygen saturations on the resident. She then placed the oximeter and thermometer (non-touch) in her uniform pocket, left the room and wiped off the wrist blood pressure cuff with the small square alcohol pads.

Employee 11 then entered Resident Q's room, obtained the blood pressure reading and started to obtain the oxygen saturations and was stopped. She exited the room and indicated she had forgotten to sanitize the oximeter. She obtained bleach wipes and sanitized the oximeter at that time.

An undated facility policy, titled, "Procedure for Cleaning Electronic Equipment", received from the Executive Director on 9/30/21 at 1 p.m., indicated the Manufacturer's Instructions were to be followed for cleaning and disinfecting. If there were no instructions, then an alcohol based wipe or spray that contained at least 70% alcohol, was to be used.

During an interview on 10/1/21 at 11:04 a.m., the

p paraid="372996606" paraeid="{b3e0c7a6-3402-473d-a12d-b2722f8ba7b6}{53}" >Fax:

Instructions for Section I: Writing an Aim Statement

It is necessary for your facility to have a clear Aim Statement when you identify an opportunity for improvement, either based on your discovery or information provided to you. It is important that you establish a measurable objective, which we refer to as Aims or Goals. The Aims/Goals are what you want to accomplish during
a quality improvement initiative. This should be clearly stated, quantifiable, and represent a challenge for your facility. An example of an Aim Statement is: “Increase the number of staff appropriately washing hands per infection prevention protocol by ___% by _______________ (date).”

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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Executive Director indicated the glucometer, oximeters, and blood pressure cuffs/machines were to be disinfected with bleach wipes and the policy would be updated.

A facility policy, dated 10/2021 and titled, "COVID-19 PPE Guidance", indicated all PPE would be used in accordance with the current CDC guidance for PPE preservation. All staff regardless of vaccination status were to have eye protection on in the Yellow Zone. A N95 mask was to be worn in the Yellow Zone, and gowns were to be used with resident care.

A facility policy, dated 8/2019, titled, "Handwashing/Hand Hygiene", received as current from the Executive Director, indicated all employees were to follow the the handwashing/hand hygiene procedures to help prevent the spread of infections. Alcohol based hand rub was to be used before and after, included direct contact with residents, before and after handling an invasive device, after contact with a resident's intact skin, after contact with objects in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings.

This Federal tag relates to Complaint IN00362842.

3.1-18(b)

p paraid="16972176" paraeid="{b3e0c7a6-3402-473d-a12d-b2722f8ba7b6}{115}"
>Quality Improvement Initiative

ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;"
Aim Statement:

Staff will adhere to the facilities infection control policies and procedures as it relates to donning and doffing of PPE, utilization of PPE (masks), equipment cleaning and disinfection, linen storage/handling, hand hygiene, safe disposal of sharps at a compliance rate of 90% by May 31, 2022.

ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color:

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			transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Provider Name: St. Anthony Home Provider #: 155214 ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Identify improvement team members: (include name and title) Cathy Wood – Administrator Amy Crossett – Interim Director of Nursing Cheryl Young – Infection Preventionist Wendy – Staff Development Adam Anderson – Regional Infection Preventionist Nick White – Regional Nurse Consultant Do you have a physician champion(s)? ¿ Yes ¿ No	

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			Name(s). William Bisset Who is the lead team member? Cathy Wood ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Provide a description of the root cause of the concern(s) identified: Problem Statement failed to ensure that staff were donning/doffing appropriate PPE when entering rooms that were on isolation precautions Staff entering room that was marked as contact and droplet isolation precautions without donning PPE Lack of knowledge/adherence to facilities policies and procedures regarding use for PPE for residents requiring	

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			isolation precautions Need for re-education and increased monitoring on appropriate donning and doffing of PPE Problem Statement: Staff failed to ensure that PPE (masks) were worn appropriately Staff observed to be wearing mask under nose throughout facility and during resident care Lack of adherence to the facilities policies and procedures related to appropriate PPE usage Need for re-education and increased monitoring to ensure staff compliance related to proper mask usage. Problem Statement failed to ensure proper handling of linens Clean Linen baskets in hallway uncovered Lack of knowledge and/or adherence to the facilities policies and procedure related to proper storage and handling of linen Need for re-education and increased monitoring to ensure that clean linen is being stored and handled according to facilities policies and procedures.	

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			Problem Statement: Facility failed to ensure that equipment was properly sanitized between residents (blood pressure cuff, blood pressure machine and glucometer) Staff used blood pressure cuff and machine to obtain blood pressure on and failed to sanitize equipment in between residents Staff used glucometer on resident and placed used glucometer in uniform pocket without sanitizing the machine. Staff lack of knowledge/adherence to facilities policy and procedure regarding equipment cleaning and sanitation Need for re-education and increased monitoring to ensure resident equipment is cleaned and sanitized according to facilities current policy and procedure. Problem Statement failed to ensure that staff were handling and disposing of sharps appropriately Staff performed blood sugar check and placed used lancet in the trash Lack of knowledge/adherence to	

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			facilities policy and procedure related to safe sharps disposal Need for re-education and increased monitoring to ensure staff adhering to the facilities policies and procedures related to safe disposal of sharps. Problem Statement failed to perform hand hygiene Staff observed to provide care to residents and exit the room without performing any type of hand hygiene on multiple occasions Lack of adherence/compliance to facilities hand hygiene policies and procedures Need for re-education and increased monitoring to ensure staff compliant with hand hygiene policies and procedures. ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="5" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Describe in detail interventions you plan to implement to address the identified concern(s). You	

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			may attach any supporting documents, including revised procedures, monitoring process, approval process, evaluation process, etc. Based on a review of recent infection control deficiencies on complaint surveys and corrective action that are being implemented with the plan of correction the following interventions were identified as opportunities to ensure that all systems continued to remain in place and are being followed according to the facilities policies and procedures. Project Plan Perform a Root Cause Analysis and develop/implement needed solutions/system changes to address findings within the RCA 14, 2021 In-services Overview of proper donning and doffing of PPE – When to don and doff PPE Sequence of donning and doffing of PPE Equipment Cleaning and Storing	

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			Glucometer Blood pressure cuff and equipment Safe Handling of Sharps Hand Hygiene Appropriate linen handling Infection Control Overview – in-service along with PowerPoint and Pre/Post Test will be provided by QIO/Infection Preventionist Bi – annual Infection Control education/in-services will be performed for all staff including a general overview as well specific infection control guidelines for each department within the facility Orientation – in addition to the required infection control will implement departmental specific infection control guidelines for each department within the facility. Monitoring Tools to be ensure infection control practices are being followed Appropriate donning and doffing and utilization of five times a week for 6 weeks, weekly times 6 weeks then monthly until	

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			end of project Appropriate equipment five times a week for 6 weeks, weekly times 6 weeks then monthly until end of project Appropriate linen handling/storage – five times a week for 6 weeks, weekly times 6 weeks then monthly until end of project Appropriate hand hygiene – five times a week for 6 weeks, weekly times 6 weeks then monthly until end of project Appropriate disposal of sharps – five times a week for 6 weeks, weekly times 6 weeks then monthly until end of project Facility will implement this monitoring on a routine quarterly basis Quarterly monitoring will be random and will cover all shifts Completed audits will be presented and reviewed in routine QAPI meetings – monitoring shall continue until substantial compliance is met Return Demonstration of Donning and Doffing of PPE and Hand be conducted with all staff and will then be conducted on an annual basis or as needed if deficiencies	

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			are present as a result of quarterly monitoring Resources from QIO on an ongoing basis throughout the project time period. Initial resources will include (but not limited too) PPE Sequencing Guide Infection Control In-service recorded link along with PowerPoint and Pre/Post Test Monitoring Tools (PPE) ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="6" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Specify start date of interventions, projected date of completion and key interim implementation dates, if there are multiple steps to full implementation. Start Date 14, 2021 End Date 31, 2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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			ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="7" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" List date(s) that improvement implementation will be evaluated. Midway Check Point 2022 Final Check and Wrap Up – ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="8" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Describe in detail how you will check progress: (include your plan for interim monitoring of cases) Touch base meetings – onsite October 2021 As needed and/or requested throughout the project Review of monthly monitoring tools by QIO – (facility to send completed monitoring tool to QIO	

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contact monthly)

Evaluation of processes during midway check point

ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="9" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;"
If needed, indicate when alternative measures would be instituted: (trigger or projected timeline)
Alternative measures will be instituted immediately if indicated by non-compliance

Need for alternative measures would be evaluated through completed audits on a monthly basis

ol class="NumberListStyle5 SCXW168837411 BCX8" role="list" start="10" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color:

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			transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Describe actions you will implement if original corrective measures are ineffective: Will meet with project team to discuss and perform an additional RCA Start performance improvement plan according to results of RCA p paraid="1217213586" paraeid="{d61f0874-cb0c-4246-8e7e-2110fc546b59}{18}" >Your final report should include answers to the following questions: Did you achieve your stated goal? (Please include a brief description of where you were and where you are now after QII conclusion) ol class="NumberListStyle1 SCXW168837411 BCX8" role="list" start="2" style="margin:	

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			0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Would you consider the improvement project you just completed a success? If “yes”, please explain why. If “no”, please explain and/or provide any barriers that may have prevented you from achieving the level of success you envisioned at the start. Did your experience lead to changes in the current protocols? p paraid="1740462302" paraeid="{d61f0874-cb0c-4246-8e7e-2110fc546b59}{83}" > Do you have any new protocols related to this improvement project that you are willing to share with others?	

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F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the			

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	immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to provide the Pneumococcal Vaccine after consent was given for 1 of 5 residents reviewed for immunizations. (Resident B) Finding includes: Resident B's record was reviewed on 9/29/21 at 10:51 a.m. The diagnoses included, but were not limited to, dementia. The Immunization Record indicated the Pneumonia vaccine of PPSV23 was administered on 1/24/13. The PCV13 pneumonia vaccination had not been given. An Informed Consent for Pneumococcal Vaccine form, dated 7/9/21, indicated a consent was given for the PCV13 pneumonia vaccination.	F 0883	F883 1:1 Regarding resident B no adverse reactions were noted from not receiving the Prevn ar 13 immunization. Physician & RP were made aware. New orders received. Education was provided to the resident & RP regarding the Prevnar 13 immunization. Consent was signed & resident C received the Prevnar 13 immunization. 1:2 The Director of Nursing/designee audited resident charts to ensure education was provided to the resident/RP regarding the Pneumococcal/Prevnar 13 immunizations. Acceptance or declination was received for the	10/18/2021

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	The Director of Nursing was interviewed on 9/29/21 at 4:58 p.m. and indicated the PCV13 pneumonia vaccination had not been administered. The Nurse who had received the order, had not entered the ordered into the computer correctly. A facility policy, titled, "Vaccination of Residents", dated 10/2019 and received from the Director of Nursing as current, indicated all residents would be offered vaccinations which would aid in preventing infectious diseases. The Informed Consent signed by the Responsible Party on 7/9/21, indicated after the PPSV23 vaccination was given, a second vaccine of PCV13, should be given.		residents who have not been previously immunized. Administration of the immunization was documented in the resident's clinical record. The Director of Staff Development re-in-serviced the staff regarding the need for resident or RP education on the benefits, potential side effects of the pneumococcal/Prevnar 13/influenza immunization, as well as the required documentation when administering the immunization. 1:3 The Director of Admissions/designee will inform the resident/RP regarding the benefits of the pneumococcal/Prevnar/influenza immunization, the potential side effects of the pneumococcal/influenza, as well as obtaining a consent or declination at the time of admission. The acceptance or declination forms will be scanned into Point Click Care. The Nurse Manager/designee will audit new admissions to ensure the pneumococcal/Prevnar 13 & influenza (when applicable) immunization acceptance/declination forms have been completed & the immunization is given if consented for six (6) months.	

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			1:4: DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor data presented for any trends & determine if further monitoring /action is necessary for continued compliance. 1:5: Systemic changes will be completed by 10-18-21.	